



# U.S. Army Aviation Epidemiology Data Register Data Entry and Flight Surgeon Office Administration Guide

by

Kevin T. Mason

Aircrew Protection Division

9 6 0 1 0 5 1 0

April 1996

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19960611 003

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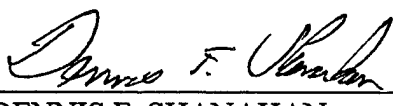
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REPORT DOCUMENTATION PAGE				Form Approved OMB No. 0704-0188	
1a. REPORT SECURITY CLASSIFICATION Unclassified			1b. RESTRICTIVE MARKINGS		
2a. SECURITY CLASSIFICATION AUTHORITY			3. DISTRIBUTION / AVAILABILITY OF REPORT Approved for public release, distribution unlimited		
2b. DECLASSIFICATION / DOWNGRADING SCHEDULE					
4. PERFORMING ORGANIZATION REPORT NUMBER(S) USAARL Report No. 96-23			5. MONITORING ORGANIZATION REPORT NUMBER(S)		
6a. NAME OF PERFORMING ORGANIZATION U.S. Army Aeromedical Research Laboratory		6b. OFFICE SYMBOL (If applicable) MCMR-UAD	7a. NAME OF MONITORING ORGANIZATION U.S. Army Medical Research and Materiel Command		
6c. ADDRESS (City, State, and ZIP Code) P.O. Box 620577 Fort Rucker, AL 36362-0577			7b. ADDRESS (City, State, and ZIP Code) Fort Detrick Frederick, MD 21702-5012		
8a. NAME OF FUNDING / SPONSORING ORGANIZATION		8b. OFFICE SYMBOL (If applicable)	9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER		
8c. ADDRESS (City, State, and ZIP Code)			10. SOURCE OF FUNDING NUMBERS		
			PROGRAM ELEMENT NO. 62787A	PROJECT NO. 30162787A878	TASK NO. HC
					WORK UNIT ACCESSION NO. DA308727
11. TITLE (Include Security Classification) U.S. Army Aviation Epidemiology Data Register data entry and flight surgeon office administration guide					
12. PERSONAL AUTHOR(S) Mason, Kevin T.					
13a. TYPE OF REPORT Final		13b. TIME COVERED FROM TO	14. DATE OF REPORT (Year, Month, Day) 1996 April		15. PAGE COUNT
16. SUPPLEMENTAL NOTATION					
17. COSATI CODES			18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)		
FIELD	GROUP	SUB-GROUP	Aviation medicine, epidemiology, database, administration, flight surgeon		
19. ABSTRACT (Continue on reverse if necessary and identify by block number) This guide provides U.S. Army flight surgeons (FS) with guidelines for completing flying duty medical examinations (FDME) that are compatible with Aviation Epidemiology Data Register (AEDR) data entry. It details the review and disposition of aeromedically disqualified aviation training program applicants, aircrew members, and air traffic controllers, both civilian and military.  The traditional core of Army aviation medicine is the delivery of clinical and operational preventive medicine services. This administration guide establishes a public health protocol as it pertains to the conduct of U.S. Army FDMEs. The FDME protocol adopts the current standard of preventive health care promoted by the U.S. Public Health Service, but is modified to meet the needs and challenges of the operational Army aviation environment. The protocol is the result of 6 years of literature review, AEDR research, and staffing of proposed aviation medicine public health policy through the U.S. Army Aeromedical Center, U.S. Army Aeromedical Research Laboratory, Army Surgeon General Aviation Medicine Consultant, and the Aeromedical Consultant Advisory Panel.					
20. DISTRIBUTION / AVAILABILITY OF ABSTRACT <input checked="" type="checkbox"/> UNCLASSIFIED/UNLIMITED <input type="checkbox"/> SAME AS RPT. <input type="checkbox"/> DTIC USERS			21. ABSTRACT SECURITY CLASSIFICATION Unclassified		
22a. NAME OF RESPONSIBLE INDIVIDUAL Chief, Science Support Center			22b. TELEPHONE (Include Area Code) (334) 255-6907		22c. OFFICE SYMBOL MCMR-UAX-SS

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### \*\*\* Section A: Background \*\*\*

#### Introduction

This guide provides U.S. Army flight surgeons (FS) with guidelines for completing a flying duty medical examinations (FDME) that are compatible with Aviation Epidemiology Data Register (AEDR) data entry. It details the review and disposition of aeromedically disqualified aviation training program applicants, aircrew members, and air traffic controllers, both civilian and military.

The traditional core of Army aviation medicine is the delivery of clinical and operational preventive medicine services. This administration guide establishes a public health protocol as it pertains to the conduct of U.S. Army FDMEs. The FDME protocol adopts the current standard of preventive health care promoted by the U.S. Public Health Service, but is modified to meet the needs and challenges of the operational Army aviation environment. The protocol is the result of 6 years of literature review, AEDR research, and staffing of proposed aviation medicine public health policy through the U.S. Army Aeromedical Center, U.S. Army Aeromedical Research Laboratory, Army Surgeon General Aviation Medicine Consultant, and the Aeromedical Consultant Advisory Panel.

Army aviation requires the highest quality of medical support in the form of a multispecialty and multidisciplinary aviation medicine program. Aviation operations directly affect the aircrew member, and indirectly the aircrew member's family. Family medicine, preventive medicine, environmental medicine, and occupational medicine disciplines are essential components of the aviation medicine program. The program promotes aviation safety, prevention of injury and chronic disease, and the maintenance of optimal psychophysiological capability. This is accomplished through unit- and family-oriented primary care, periodic medical examinations, flight line visits and inspections, participation in aviation missions, immunizations, chemoprophylaxis, promotion of healthy lifestyles, and various programs to detect asymptomatic, treatable diseases.

The aviation medicine program must be readily and continuously available to Army aviation units, detachments, and activities throughout the Army. This requires a significant effort compared to other Army medical programs. Reasons for these requirements include maintaining the operational readiness of Army aviation in combat and combat support; the high dollar value of aviation personnel and equipment; the long lead time and high cost of replacing aircrew members and assets lost due to human factor mishaps, injury, and chronic diseases; and the cost of decreased operational capability due to medically preventable illness in aircrew members.

#### Definitions and responsibilities

##### Definition of terms

Appendix A lists aeromedical terms and abbreviations used in this guide. Army Regulation 40-501, Medical fitness standards, and Army Regulation 600-105, Aviation service, provide additional definitions, policies, and standards pertaining to aviation duties.



## Applicability

This guide applies to FDMEs and aeromedical summaries accomplished for aircrew members performing aviation or air traffic control (ATC) duties in Department of the Army (DA) aircraft, aircraft leased by the DA, or Army ATC facilities. This includes Active Army and Reserve Component personnel, Department of the Army civilians (DAC), and contract civilians under employment by the DA or firms under contract to the DA.

## Flying duty medical examination

The FDME is a periodic, screening physical examination performed for occupational and preventive medicine purposes to promote and preserve the fitness, deployability, and safety of aviation personnel and resources. FDMEs are used as a starting point for the careful evaluation and treatment of aircrew member health problems. FDMEs focus on the health history, vision, hearing, and cardiopulmonary and neuropsychiatric systems. The FDME and supporting documents provide information so aviation authorities and Commander, U.S. Army Aeromedical Center (USAAMC), can make a final determination of medical fitness for flying and air traffic control duties.

## Responsibilities

The Army Surgeon General (TSG) is responsible for the Army Aviation Medicine Program. TSG is the proponent for all aeromedical policy and standards.

Installation commanders, installation medical authorities, command surgeons, and aviation unit commanders implement the Army Aviation Medicine Program at the local level by providing trained personnel, equipment, and facilities for the proper conduct of the program. They ensure the expeditious, accurate completion of FDMEs and aeromedical summaries by military FSs and Aeromedical Physician Assistants.

The Commander, U.S. Army Aeromedical Center (USAAMC), is authorized to establish the U.S. Army Aeromedical Activity (USAAMA) and the Aeromedical Consultant Advisory Panel (ACAP). The Commander, USAAMC, in coordination with the ACAP and the TSG Aviation Medicine Consultant, issues Aeromedical Policy Letters (APL) and Aeromedical Technical Bulletins (ATB) to establish aeromedical policy and standards, ensuring the continuity and quality of the aeromedical standard of care for Army aircrew members worldwide.

## U.S. Army Aeromedical Activity

The Commander, USAAMC, establishes USAAMA, which coordinates through Commander, USAAMC, with TSG, TSG Aviation Medicine Consultant, and Chief, Army Aviation Branch, to:

1. Develop, implement, and continuously assess aeromedical policy and standards for issues such as medical selection and retention of aircrew, operational effectiveness of aircrew, longevity of aircrew careers, and aviation safety.

2. Make a final recommendation of medical fitness for flying duties, waivers, exceptions to policy, and medical termination from aviation service of aircrew and aircrew training candidates by the central review, study, and analysis of FDMEs and aeromedical summaries.

3. Organize and manage the ACAP. ACAP provides a consensus of opinion for the Commander, USAAMC, and the TSG Aviation Medicine Consultant on issues pertaining to aviation medicine policy, standards, and aeromedical fitness for flying duty, including issues of deployability, personal and aviation safety, and medical/administrative factors in personnel management.

4. Provide for aeromedical specialty consultation and medical in-flight evaluations through management of the U.S. Army Aeromedical Consultation Service (AMCS). The AMCS is established at USAAMC for the centralized, tertiary aeromedical evaluations and aeromedical in-flight evaluations of aircrew members who do not meet the medical fitness standards for flying duties. Requests for aeromedical consultation are forwarded for review and approval through a military flight surgeon to the Commander, USAAMC, ATTN: MCXY-AER, Bldg. 301, Fort Rucker, AL 36362-5333; DSN 558-7430/7411 or COMM (334) 255-7430/7411. Commander, USAAMC, also approves and refers selected, eligible (AR 40-3), medically disqualified military, DAC, or contract civilian aircrew to the aeromedical consultation services of the U.S. Navy and U.S. Air Force when approved by appropriate medical authority of those services. AR 40-501, paragraph 6-9e, defines payment of consultation services for military and civilian aircrew members.

5. Implement quality assurance and improvement review of FDMEs and Aeromedical Summaries.

6. Support education/training pertaining to aeromedical policy, standards, and regulations.

7. Develop Memorandums of Understanding with Chief, Army Aviation Branch, as required, for outlining operational and administrative procedures that coordinate the Army Aviation Medicine Program with the Army Aviation Program.

8. Maintain a permanent aeromedical database on Army aircrew members.

9. Perform other missions as tasked.

#### Aviation Epidemiology Data Register (AEDR)

The AEDR is a permanent Department of the Army-directed aeromedical database on Army aircrew. The AEDR mission is tasked to TSG. The operation of the database is jointly established and managed by the U.S. Army Aeromedical Center and the U.S. Army Aeromedical Research Laboratory, Fort Rucker, Alabama, 36362. The AEDR is used to assess the adequacy of and modify aeromedical policy and standards through epidemiological study, to develop a basis for entry and retention medical standards in aviation specialties, and to conduct aeromedical research and development in support of the Army aviation mission and Army Aviation Medicine Program. The AEDR supports review and disposition of aeromedical disqualifications, aviation medicine clinical care, clinical investigations and publications, medicolegal actions, Congressional and command inquiry, aircrew operational readiness, and aviation personnel administration.

The AEDR is a family of databases related by the aircrew member's Social Security number. The FDME computer database stores all FDME data elements for Class 1/1A, 2/2F/2S, and 4 (formerly Class 2A, ATC) FDMes beginning in 1985. The Waiver and Suspense file database contains an index of major aircrew member health problems that references an image data library containing the clinical details of each health problem. The image library consists of Microx® records (circa 1985 to 1993) and digital laser optic records (circa 1994 to present).

### Echelons of preventive care in Army aviation medicine

#### General principles

Preventive medicine is an essential part of the aviation medicine program. The FDME is the focus of the screening portion of the prevention program. Flight surgeons maintain and promote the health and well-being of aviation personnel. This effort ensures an effective fighting force and enhances aviation safety. The preventive medicine initiatives are primary, secondary, or tertiary; and involve, as a minimum, six elements: health education, immunizations, disease surveillance, environmental control, early intervention, and rehabilitation.

#### Primary prevention

Flight surgeons develop health education programs. They present health information during aviation unit meetings, professional development classes, flight line visits, safety meetings, mission briefings, and physiologic training classes. Table 1 shows some important health education topics.

Table 1.  
Basic health education initiatives for aviation medicine.

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Cardiovascular disease risk factor reduction.
Limiting self-imposed stresses, such as use of caffeine, drugs, alcohol, and nicotine.
Dangers of flying during illness or after taking over-the-counter medications.
Crew rest and fatigue, and enhancement of crew endurance.
Environmental hazards on the flight line or deployments, such as weather-related injuries, noise damage to hearing, poisonous flora and fauna, field sanitation, and personal hygiene.
Physical conditioning and sports injury prevention.

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Flight surgeons maintain the immunization status of the aviation personnel. The immunization program is based on Army preventive medicine guidelines and the mission requirements of the unit. Flight surgeons conduct disease surveillance looking for opportunities to implement prevention strategies. Through regular communication with local preventive, environmental, and occupational medicine health care professionals, flight surgeons assess how disease trends in the general community affect the aviation population. Timely intervention reduces morbidity in aircrew members.

Through inspection and participation, flight surgeons intimately become familiar with the environmental conditions and hazards faced by aircrew members that reduce their effectiveness or result in disease or injury. Flight surgeons inspect and evaluate aircrew member rest, eating, latrine, and work areas, ensuring that aircrew members are protected from environmental factors and that safety precautions are in effect. Flight surgeons ensure that sanitary standards are maintained during operational deployments. Clean water, properly prepared food, handwash facilities, and sanitary disposal of sewage and food are important elements of disease prevention in the field.

### Secondary prevention

Through frequent contact in social and clinical settings, by observation on the flight line, and by annual flying duty medical examinations, flight surgeons intervene in disease processes that affect flight safety and aviation mission completion. Examples of diseases in the aeromedical setting amenable to secondary prevention and early intervention include: alcoholism, coronary artery disease, hearing loss, ocular hypertension and glaucoma, hypertension, valvular heart disease, tuberculosis, and certain malignancies, especially of the testicle, prostate, breast, female genitourinary tract, thyroid gland, skin, and colon.

### Tertiary prevention

Flight surgeons ensure the appropriate coordination of medical and ancillary care in the rehabilitation of grounded aircrew members following a severe injury or illness. The goal is to eventually return the aircrew member to flying duties, or continued duty in support of the aviation mission, such as education, safety, product development.

\*\*\* Section B: Flying duty medical examinations (FDMEs) \*\*\*

Medical standards classification of FDMEs

Table 2 lists the medical standards classifications for U.S. Army flying duties. The medical standards of fitness are detailed in Chapter 2 and 4 of Army Regulation 40-501, Medical fitness standards. The class of medical standards applied by the examiner during the FDME is recorded in Item 5, Standard Form 88, and Item 7, DA Form 4497-R. AEDR codes for medical standards classification are listed in Appendix B.

Table 2.  
Medical standards classifications for flying duties.

Class	Applies to-
Class 1	Warrant officer applicants to U.S. Army aviator training
Class 1A	Commissioned officer applicants to U.S. Army aviator training
Class 2	All U.S. Army aviators or student aviators Department of the Army and contract civilian pilots flying aircraft owned and operated by the Department of the Army
Class 2F	Flight surgeons Aeromedical physician assistants
Class 2S	Aeroscout observers (MOS 93B) Aerial fire support observers (MOS 13F)
Class 3	Individuals required by a competent authority to participate in regular aerial flights as nonrated personnel, e.g. crew chiefs, flight mechanics, flight medics, aerial observers, aerial gunners, and altitude chamber technicians
Class 4	Military air traffic controllers (ATC) Department of the Army and contract civilian ATCs

Flight surgeons may conduct occupational examinations using other medical standards classifications. They may examine and/or review the examination of high altitude freefall specialists, diving engineers, diving specialists, altitude and hyperbaric chamber technicians, members of other U.S. military services and Allied Forces members on flight status, and U.S. Army applicants to the National Aeronautics and Space Agency.

### Purpose of FDMEs

The purpose of the FDME is recorded in Item 5, Standard Form 88. The four purpose categories for FDMEs are initial, Fort Rucker abbreviated for Class 1/1A, comprehensive, and interim. AEDR codes for the medical classification and examination purpose are in Appendix B.

### Initial FDME

Initial FDMEs are performed on all Classes 1/1A aviator training program applicants; and all other classes applying for or awaiting initial aviation or aviation medicine training, interservice transfer, transition from Active Duty to Reserve Components, or hiring into the DA civilian or contract civilian aircrew work force. The results of initial FDMEs are recorded on Standard Forms 88 and 93, and aeromedical continuation Standard Form 93. The examination requirements for Initial FDMEs are found in Appendixes C, D, and E.

### Fort Rucker Abbreviated Class 1/1A FDME

Classes 1/1A aviator training program students must have a valid, USAAMC approved, initial Class 1/1A FDME before acceptance into aviator training programs and upon arrival for flight training at Fort Rucker. USAAMC performs a Fort Rucker abbreviated (FRA) Class 1/1A FDME before the student is enrolled in flight training to revalidate the student meets Class 1/1A medical standards of fitness for flying duties. Commander, USAAMC, will maintain standard operating procedures for the conduct of FRA Class 1/1A FDMEs. The Fort Rucker abbreviated FDMEs are recorded on Standard Forms 88 and aeromedical continuation Standard Form 93. Document interim changes in medical history on Standard Form 93 if these changes were not previously documented on an USAAMA AEDR medical history verification report (Appendix M) or aeromedical summary.

### Comprehensive FDME

Comprehensive FDMEs are performed on all classes of aircrew when initial FDMEs or interim FDMEs are not required. The results of the comprehensive FDME are recorded on Standard Forms 88. Document interim changes in medical history on Standard Form 93 if these changes were not previously documented on an USAAMA AEDR medical history verification report (Appendix M) or aeromedical summary (Aeromedical technical bulletins 3 and 4). The examination requirements for comprehensive FDMEs are found in Appendixes C, D, and E.

### Interim FDME

Abbreviated interim FDMEs are performed on all classes of aircrew when initial FDMEs or comprehensive FDMEs are not required. The results of the interim FDME are recorded on DA Form 4497-R found in AR 40-501, page 85. Record interim changes in medical history on Standard Form 93 if these changes were not previously documented on an AEDR medical history verification report or aeromedical summary. The examination requirements for interim FDMEs are in Appendix F.

## Frequency and period of validity of FDMEs

### Classes 1/1A

#### Initial Class 1/1A FDME

The initial Class 1/1A FDME is valid for a period of 18 months from the date of examination. Repeat initial FDMEs are required if the FDME validity expires while awaiting aviator training program selection or training class dates. The FDME must be valid and qualified by the Commander, USAAMC, before the applicant's acceptance into aviator training programs and upon arrival for flight training.

#### Fort Rucker Abbreviated Class 1/1A FDME

This FDME is valid until the last day of the birth month following completion of initial flight training resulting in the aviation service designation of "rated aviator." See also "Purpose of examination" section above.

### Classes 2/2F/2S/3/4

#### Initial FDME

The initial FDME is valid for a period of 18 months from the date of examination. Following the initial FDME, subsequent comprehensive or interim FDMEs will be aligned with the aircrew member's birth month using Appendix G.

#### Comprehensive FDME

The comprehensive FDME is performed at ages 19, 22, 25, 28, 31, 34, 37, 40, 43, 46, 49, and then annually thereafter. Perform the FDME within 90 days before the end of the birth month. The FDME is valid until the last day of the next birth month.

A comprehensive FDME is required when a disqualifying illness or injury is present for more than 180 days, and when an aircrew member is requesting return to aviation service after medical termination from aviation service. A comprehensive FDME may be required during a post-mishap investigation or flying evaluation board (AR 600-105, Aviation service).

Aircrew members on active duty are required to complete a comprehensive FDME, with the additional requirements for retirement, prior to retirement (AR 40-501, Chapter 8-12d and 8-23c). For reserve components and civilian aircrew members, a retirement comprehensive examination is recommended, but not required (AR 40-501, Chapter 6-8b(6)).

### Interim FDME

The interim FDME is performed in the interim years when an initial or comprehensive FDME are not required. Perform the FDME within 90 days before the end of the birth month. The FDME is valid until the last day of the next birth month. If the aircrew member has submitted retirement papers, the interim FDME validity may be extended to 18 months, pending completion of the retirement comprehensive examination (see above, comprehensive FDME).

### Additional requirements

Rated aviators in aviation service maintain an annual medical certification by a Class 2 FDME, even when not assigned to operational flying duty positions (AR 600-105, Aviation service).

The requirement to perform FDMEs will not be suspended in the event of training exercises or military mobilization unless authorized by TSG. Request authorization through the Commander, USAAMC, MCXY-AER, Fort Rucker, AL 36362-5333, to TSG Aviation Medicine Consultant.

When aircrew members are on duty or mobilization at OCONUS stations with limited military medical facilities, accomplish the FDME to the extent medical treatment facilities permit. Place a memorandum on the FDME explaining the facility limitations. Accomplish a comprehensive FDME within 90 days upon return to a station with adequate medical facilities. Align subsequent comprehensive or interim FDMEs with the aircrew member's birth month using Appendix G.

During certain missions not supported by U.S. or Allied military medical officers (such as exceptional Special Operations Branch missions), the FDME may be deferred by the commander having custody of the field personnel files until the accomplishment of the FDME becomes feasible. Annotate DA Form 4186, remarks, with an unclassified explanation of the deferment.

### Facilities and examiners

#### Initial FDMEs

U.S. military (DOD, uniformed) flight surgeons and APAs at U.S. military (DOD) medical treatment facilities will conduct initial FDMEs. Initial FDMEs will meet all the U.S. Army-specific administrative requirements. The flight surgeon will apply U.S. Army aeromedical standards from Chapters 2 and 4, AR 40-501, for the determination of medical fitness for flying duty.

#### Comprehensive FDMEs and Interim FDMEs

Comprehensive FDMEs and Interim FDMEs for all classes, except Classes 1/1A, are conducted when possible by military flight surgeons. The FDME may be conducted by any military, DAC, or contract civilian physician when a flight surgeon is not available, but a flight surgeon or aeromedical physician assistant will review and sign the Standard Forms 88 and 93, or DA Form 4497-R, prior to sending the FDME to USAAMC for central review.



When a FDME is performed at non-U.S. Army medical facilities, the FDME will be conducted by a military flight surgeon to meet the administrative requirements of that branch of the U.S. Armed Forces or host Allied nation. The flight surgeon must apply APL 28, Cardiovascular disease screening, and Army aeromedical standards from Chapters 2 and 4, Army Regulation 40-501, for the determination of medical fitness for flying duties. FDMEs performed by host Allied nations may be completed in English on Allied FDME forms when Standard Forms 88 and 93 are not available. Outline unusual circumstances or lack of medical equipment for FDME testing in a memorandum for record included with the FDME.

#### Additional requirements

Aeromedical physician assistants may conduct FDMEs. The FDME must be reviewed and cosigned by the supervising physician. Other physicians and health care professionals will sign the Standard Form 88 for the portions of the examination they accomplish. The FDME is invalid and incomplete without the signature of a military flight surgeon or aeromedical physician assistant on the Standard Forms 88 and 93, or DA Form 4497-R, and a final review stamp placed by the proper authorities at USAAMC on the Standard Form 88, or DA Form 4497-R.

DAC or DA contract civilian physicians with previous military aeronautical rating of flight surgeon or APA, or military flight surgeons and APAs practicing in medical specialties other than aviation medicine, may be credentialed to complete FDMEs. U.S. Army School of Aviation Medicine provides Army aviation medicine refresher training for flight surgeons and aeromedical physician assistants to meet credentialing requirements.

#### Medical consultations

Consultations may be obtained at Government expense when authorized as stated below:

Initial FDMEs for all aircrew classes, to include civilians, active and reserve components. Additional tests, procedures, and consultations required to complete Initial FDMEs will be accomplished at military outpatient or inpatient medical treatment facilities when fitness for flying duty cannot be determined. Military medical treatment facility commanders or National Guard State Adjutant General's Office may permit supplementary examinations from civilian medical sources. *The tests and consultations are conducted only to the extent required to determine initial medical fitness for flying duties, and does not include treatment or correction of disqualifying conditions.*

Comprehensive FDMEs and interim FDMEs. The above guidelines for initial FDMEs apply, *except treatment or correction of disqualifying conditions will be completed if the examinee is eligible for medical care as defined by Army Regulation 40-3.*

DAC or contract civilians employed by DA or firms under contract by DA who are also military retirees, Reserve Component, or National Guard aircrew members, may be authorized for treatment or correction of disqualifying conditions as defined by Army Regulation 40-3.

DAC or contract civilian employed by DA or firms under contract by DA who are not eligible for care as defined in Army Regulation 40-3, will be advised to consult a private physician of their choice at their own expense once it is determined during a FDME or interim evaluation that they are medically disqualified for Army aircrew duties. These disqualified civilians are also responsible for the costs of additional tests, procedures, and consultations that may be required by Commander, USAAMC, to determine if the disqualified civilian aircrew member is eligible for a waiver, or for a continuation of a waiver.

Commander, USAAMC, may direct evaluation of disqualified aircrew eligible for military medical care at any U.S. military medical treatment facility or aeromedical consultation service. The military aircrew member's unit is responsible for temporary duty costs (travel and per diem) to obtain recommended medical evaluations. Civilian aircrew members eligible for evaluation and care are responsible for their own travel and per diem costs.

### Disposition and review of FDMEs

#### General

The FDME is completed following the item by item format outlined in the Appendixes. The review of the individual health record and FDME will be accomplished by a flight surgeon or APA. The examinee's current PULHES profile status is recorded in Item 76, Standard Form 88. The flight surgeon or APA will counsel the examinee regarding:

1. Conditions found during the FDME.
2. Continuing care for conditions under treatment and/or waiver.
3. General preventive health education, including, but not limited to, smoking cessation, cholesterol control, weight control, drug and alcohol abuse, and other high risk behaviors.

#### Class 1/1A and Initial Class 2/2F/2S/4

Completed FDMEs (originals of Standard Forms 88 and 93, aeromedical continuation of Standard Form 93, interpreted electrocardiographic tracings, and other supportive documents) accomplished for application to aviation and aviation medicine training programs will be forwarded through the procurement chain of command of the applicant to Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333, for central aeromedical review and disposition. The FS's office will retain a copy of the FDME and all enclosures for a minimum of 2 years. In no case will the originals be given to the applicant or other individuals not in the procurement chain of command. Commander, USAAMC, must make a final recommendation of fitness for flying duties before Class 1/1A/2F/2S/4 applicants may be accepted and assigned to Fort Rucker for aviation and aviation medicine training programs.

### Trained Classes 2/2F/2S/4

Completed comprehensive and interim FDMEs (originals of Standard Forms 88 and 93, DA Form 4497-R, interpreted electrocardiographic tracings, and other supportive documents, which may include consultations, electrocardiographic tracings, radiographs, coronary angiogram, etc.; and if applicable, aeromedical summary) will be directly forwarded to the Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333, for central aeromedical review and disposition. The FSs office will retain a copy of the FDME and all attachments for a minimum of 2 years.

### Initial and trained Class 3

The attending flight surgeon who signs the FDME is the reviewing authority for recommending disposition on medical fitness for flying duty Class 3. Individuals with minor medical disqualifications, which will in no way affect the safe and efficient performance of flying duties and will not be aggravated by aviation duties or deployment, may be waived by the individual's unit commander upon favorable recommendation by the attending flight surgeon.

### Issuing DA Form 4186

DA Form 4186, Recommendation for Flying Duty, is an official document used to notify the aviation commander of the initial recommended certification of medical fitness for all classes of military and civilian aircrew. DA Form 4186 will be completed :

1. After the completion of an FDME.
2. After an aircraft mishap.
3. After a flying evaluation board (AR 600-105, Aviation service).
4. When reporting to a new duty station or upon being assigned to operational flying duty.
5. When admitted to and discharged from any medical or dental treatment facility (inpatient or outpatient, military or civilian), sick in quarters, interviewed for or entered into a drug/alcohol treatment program, or when treated by a health care professional who is not a military flight surgeon.
6. When treated as an outpatient for conditions or with drugs which are disqualifying for aviation duties; and upon return to flight duties after such treatment and recovery.
7. Upon return to flight status after termination of temporary medical suspension, issuance of waiver for aviation service, or requalification after medical or nonmedical termination of aviation service.
8. Other occasions as required by the flight surgeon, or Commander, USAAMC.

Rated aviators not performing operational flying duties are required to complete an annual FDME with issuance of DA Form 4186.

Each item of the DA Form 4186 will be completed as directed by Commander, USAAMC. Three copies of the DA Form 4186 will be completed. Copy 1 is placed in the outpatient medical record. Copy 2 is forwarded to the examinee's unit commander who signs and forwards it to the flight operations officer for inclusion in the flight records. Copy 3 is given to the examinee.

If the examinee is found qualified by the local flight surgeon for flying duty by Chapters 2 and 4, AR 40-501, issuance of the DA Form 4186 constitutes an aeromedical recommendation of clearance for flying duty pending final review of the FDME by the reviewing authority. The aeromedical clearance will expire when the current FDME is no longer valid.

If a disqualifying medical condition is found, the waiver authority must grant a waiver before flying duties are performed. For minor defects that will not preclude safe and efficient performance of flying duties, and will not be aggravated by aviation or military mission, the local commander may permit an individual to continue performance of aviation duties pending completion of the formal waiver process, and upon favorable recommendation for temporary full flying duties by the attending flight surgeon, following the guidelines in Aeromedical Policy Letter 21.

When used to recommend temporary full flying duties pending receipt of waiver, the Remarks section of DA Form 4186 will be completed to reflect a limited length of time for which the clearance is issued; such as "Temporary full flying duties, 90 days, pending receipt of waiver."

The flight surgeon will consult the Commander, USAAMC, ATTN: MCXY-AER, or the appropriate MACOM Aviation Medicine Consultants in U.S. Army Europe or Korea, before issuance of DA Form 4186 for complex or questionable cases.

The validity period of the current FDME may be extended for a period not to exceed 30 days on DA Form 4186. After expiration of this extension, the aircrew member or ATC must complete the FDME and be medically qualified, or be:

1. Administratively restricted from flying duties if no aeromedical disqualification exists, and be considered for a nonmedical disqualification and flying evaluation board (AR 600-105).
2. Medically restricted from flying duties if a medical disqualification exists. In some cases temporary flying duties may be recommended on DA Form 4186 (Aeromedical policy letter 21).

Personnel authorized to sign the DA Form 4186 are:

1. Any physician or health care provider may sign DA Form 4186 for recommending restriction of aircrew and ATCs from aviation duties when an aeromedical disqualification exists.

2. Only a flight surgeon may sign the DA Form 4186 to recommend returning aircrew members or ATCs to full flying duties. Recommended restrictions will be annotated in the Remarks block of DA Form 4186.

3. Non-flight surgeon medical officers, or APAs under the supervision of a flight surgeon, may sign the DA Form 4186 to recommend returning aircrew and ATCs to full flying duties when a flight surgeon is not locally available by obtaining a telephonic consultation with a flight surgeon. Record the FS's name, rank, and FS designation in the Remarks block of DA Form 4186. In the case of an APA, the FS will review the medical record and cosign the DA Form 4186 within 72 hours.

Forms of the other branches of the U.S. armed forces and host Allied nations similar to DA Form 4186 may be used when aeromedical support is provided by those services and DA Form 4186 is not available.

\*\*\* Section C: Review and disposition of disqualifications \*\*\*

General principles

Background

Commander, U.S. Army Aeromedical Center (USAAMC), is authorized to issue Aeromedical policy letters (APL Series) and Aeromedical technical bulletins (ATB series) that are regulatory in nature. These detail aeromedical policy and disposition for common aeromedical disqualifications and establish an Army-wide standard of aeromedical care. These series may be obtained from Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333; DSN 558-7411/7430 or COMM (334) 255-7411/7430.

For the purpose of aeromedical disqualifications, the immediate aviation commander is defined as the aviation unit commander or designated official who maintains the aircrew member's flight or ATC records.

Medical standards of fitness

The flight surgeon will make the initial determination of medical unfitness due to a failure to meet a medical standard for:

1. Aircrew duties. Chapters 2 and 4, Army Regulation 40-501, outline the medical fitness standards for aircrew duties. The final determination of medical fitness for flying duties is made by the Commander, USAAMC. Although medical and physical evaluation board documents (Army Regulation 635-40) are a valuable source of information, the final recommendation of medical fitness for flying duty is made independent of the recommendations of these boards. The Commander, USAAMC, may review the proceedings of flying evaluation boards in determining fitness for flying duties.

2. Service member retention, retirement, or separation. Chapter 3, Army Regulation 40-501, outlines the medical fitness standards for service member retention, retirement, or separation. The final determination of medical fitness for service member retention, retirement, or separation is made by the Medical and Physical Evaluation Board process as per Army Regulation 635-40. In the case of aircrew disqualified by Chapter 3, Army Regulation 40-501, the president of the physical evaluation board may request consultation from the Commander, USAAMC, or delay final deliberations until the medical fitness for flying duties is recommended by the Commander, USAAMC.

Examination

The flight surgeon will complete a history, physical, tests, procedures, and consultations to the extent required to:

1. Confirm the medical disqualification.

2. Recommend an aeromedical disposition.

3. Meet the aeromedical standard of care in accordance with AR 40-501, aeromedical policy letters and technical bulletin series.

### Aeromedical decision guidelines

#### The medical condition

For all flying duty classes, evaluate each disqualifying defect or condition to determine if it:

1. Is progressive.
2. Is subject to aggravation by military and/or aviation service.
3. Precludes satisfactory completion of training, and/or aviation service.
4. Constitutes an undue hazard to the individual or to others.

#### Medications

The flight surgeon will consider the factors involved in the use of medications (Aeromedical policy letter 9, Medications) for treatment of the condition and determine if:

1. The medication is effective without aeromedically significant side effects.
2. There is a problem with medication compliance.
3. The medication is readily available during mobilization or deployment.
4. The medication does not mask symptoms subject to acute incapacitation or complications in the aviation environment.

#### Implication of flying duties

The flight surgeon will consider whether continued flying duty may:

1. Compromise personal health.
2. Pose a risk to aviation safety.
3. Jeopardize mission completion.
4. Result in deployability limitations.

### Date of medical incapacitation

The flight surgeon recommends the initial date of medical incapacitation (DMI). The DMI is the date the aeromedical disqualification is diagnosed by history, physical examination, or medical testing. The date of aeromedical incapacitation may not always correspond with the date of local medical restriction from flying duties by a flight surgeon using DA Form 4186, Medical recommendation for flying duties, or the date a flight surgeon first evaluates the disqualification.

For example, an aviator on leave has the diagnosis of kidney stone made by intravenous pyelogram at a civilian hospital on 1 July. The flight surgeon sees the aviator on 20 July. The DMI is retroactive to 1 July, while the date the flight surgeon signs the DA Form 4186 is 20 July as noted on the flight surgeon signature block. In another example, an aviator presents on 15 December for blood in the stool. The initial DMI is 15 October. As a result of medical tests, a definitive diagnosis of ulcerative colitis is made by colon biopsy on 28 November. Termination from aviation service is recommended for the ulcerative colitis, but USAAMA may recommend to the waiver authority to adjust the final DMI to 28 November, the date the permanently disqualifying condition, ulcerative colitis, was diagnosed by biopsy.

### Final aeromedical disposition of disqualifications

Each aeromedical disqualification requires:

1. Temporary medical suspension until the aircrew member is requalified and meets the medical fitness standards for flying duties within 365 days [Note: formerly 180 days] (Army Regulation 600-105; DOD Directive 7730.57, Assistant Secretary of Defense, 1994 [Note: This directive changed the period of temporary suspension from 180 to 365 days]); or,
2. Medical termination from aviation service (permanent medical suspension) due to a temporary medical suspension imposed for greater than 365 days [Note: formerly 180 days], or a permanent aeromedical disqualification without waiver; or,
3. Aeromedical waiver granted by the aviation service waiver authority permitting aviation service despite an aeromedical disqualification.

### Responsibilities

#### Aircrew members

Aircrew members will report to a flight surgeon a history of the following conditions:

1. Symptoms indicating a change in health.
2. Illness requiring the use of medication, visit to a health care provider for evaluation and/or medical-dental care, restriction to quarters, or hospitalization.



3. Drug or alcohol use that results in legal problems (driving under the influence, positive blood or urine drug screen, arrests for intoxication, family member abuse, etc.), psychosocial dysfunction (absence or tardiness from work or school, severe marital discord, etc.), medical or psychological incapacitation, or history of evaluation and/or treatment for drug/alcohol abuse or dependence.

4. Current aeromedical waivers or requests for waivers.

5. HIV seropositivity.

#### Aviation commander

The immediate aviation commander will request an aeromedical consultation with a local flight surgeon when an aircrew member develops a change in health.

#### Flight surgeon

The local flight surgeon will make a preliminary determination of medical fitness for flying duties and recommend full flying duties, or duties not to include flying, by issuance of DA Form 4186. The flight surgeon prepares an FDME and aeromedical summary (aeromedical board process), as required, and forwards these to the Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333.

#### Commander, USAAMC

In the case of a permanent aeromedical disqualification, the Commander, USAAMC, ATTN: MCXY-A, Fort Rucker, AL 36362, makes the final recommendation of medical fitness for flying duties to the aviation service waiver authority. Aeromedical consultation authority is Commander, USAAMC, ATTN: MCXY-AER (Chief, Aeromedical Consultation Service), Fort Rucker, AL 36362-5333, DSN 558-7430 or COMM (334) 255-7411/7430.

#### Aviation service waiver authority

The aviation service waiver authority reviews the recommendation of medical fitness for flying duties and makes the final administrative disposition for:

1. Medical termination from aviation service (permanent medical suspension); or,
2. Continuation of aviation service with an administrative aeromedical waiver.

The aviation service waiver authorities are listed in Appendix J.

### Review and disposition of disqualifications for Classes 1/1A

The flight surgeon who signs the FDME will examine all entries to determine that the examination is complete and the examinee is qualified. Outcomes of the review include:

1. If the review confirms the applicant is qualified, forward the FDME to Commander, USAAMC for review.
2. If the examinee has a minor physical defect(s) that is disqualifying, complete the FDME and record the details of the defect(s). Forward the FDME to Commander, USAAMC, ATTN: MCXY-AER, for review and final determination of the aeromedical fitness for flying duties.
3. If one or more major disqualifying defects exist, the FDME need not be completed. However, forward the incomplete FDME to Commander, USAAMC, for reference in the event of future re-examination of the applicant. Failure to meet the prescribed standards for vision and/or refractive error, hearing, or anthropometrics are examples of major disqualifying defects.

U.S. Army student aviator candidates will not enter flight training schools with a medical disqualification. They are not eligible for aeromedical waivers for the medical disqualification. Entrance into U.S. Army aviator training programs with a disqualifying medical defect requires an "exception to policy" issued by aeromedical waiver authorities at the Department of the Army or National Guard Bureau. Exceptions to policy are granted only to Commissioned Officer candidates by regulation. Exceptions to policy are granted only to exceptional Commissioned Officers with minor, static medical disqualifications. Exceptions to policy are not likely to be recommended for disqualifying conditions that are dynamic and may progress with time, are prone to recurrence or exacerbation with military and/or aviation duties, or affect aviation safety and operations. To request an exception to policy, the flight surgeon submits an aeromedical summary through Cdr, USAAMC, ATTN: MCXY-AER, Fort Rucker, Alabama, 36362, to the appropriate waiver authority. The applicant will enclose documents with the aeromedical summary for review by the waiver authority documenting why the applicant is truly exceptional. The Cdr, USAAMC, makes a medical recommendation to the waiver authority based on the condition. The waiver authority grants or denies the exception to policy based on the medical recommendation and the needs of the Army.

### Review and disposition of disqualifications for Class 3

The flight surgeon who signs the FDME is the reviewing authority and makes decisions on aeromedical disposition. Minor physical defects that will not affect the safe, efficient performance of flying duties or mission, and will not be aggravated by aviation duties or deployment, may be waived by the individual's unit commander, the Class 3 waiver authority, upon favorable recommendation by the flight surgeon. Recommend Class 3 aircrew with a major physical or psychological disqualification for medical suspension from flying duties. Forward notification of disqualification on DA Form 4186 to the aviation unit commander, with recommendations for waiver of disqualifications or medical suspension from flying duties in accordance with existing directives. Prepare an aeromedical summary to include the basis for aeromedical recommendation. Place it in the aircrew member's individual health record for future reference. Forward cases involving drug/alcohol abuse or dependence, HIV seropositivity, suspected or proven coronary

artery disease, decompression sickness, or complicated, questionable cases to the Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333, for review and disposition.

The flight surgeon considers the operational duties and responsibilities of Class 3 aircrew before recommending a waiver/suspension action to the aviation unit commander. A major physical or psychological defect in the operational Class 3 aviation environment is defined as any defect that:

1. Interferes with duties requiring visual or auditory acuity, speech clarity, dexterity, or adequate range of motion.
2. Interferes with aviation life support equipment, or use of controls at their duty station.
3. Reduces ability to withstand rapid changes in atmospheric pressure or acceleration forces.
4. Increases the risk of sudden incapacitation, compromising personal health, aviation safety, mission completion, or deployability.
5. Requires medications or treatments that compromise flight safety or deployability.

#### Review and disposition of disqualifications for Classes 2/2F/2S/4

##### General

Submit initial and periodic FDME's to Commander, USAAMC, for review and disposition following FDME routing policy. The flight surgeon prepares a DA Form 4186 and recommends clearance for full flying duties for medically qualified aircrew members. If a disqualifying defect is discovered, the flight surgeon completes the evaluation and recommends temporary medical suspension, medical termination from aviation service, or waiver of the disqualifying defect.

##### Temporary medical suspension

Temporary medical suspension restricting aircrew from flying duties is required for temporary aeromedical disqualifications that are minor, self-limited, and likely to result in requalification within 365 days [Note: formerly 180 days; Assistant Secretary of Defense, 1994]. Examples include ankle sprain, acute rhinitis, gastroenteritis, simple closed fracture.

Medical termination from aviation service is mandatory if the temporary medical suspension exists for greater than 365 days [Note: formerly 180 days; Assistant Secretary of Defense, 1994]. In this case, the temporary medical suspension becomes a permanent medical disqualification.

The local flight surgeon will evaluate all aircrew with possible aeromedical disqualifications as identified by the aviator, immediate aviation commander, flight surgeon, or USAAMC. The flight surgeon will follow the established standards of aeromedical care found in the regulations and policy letter series. The flight surgeon will recommend a date of medical incapacitation and recommend duties not to include flying (DNIF) on DA Form 4186.

The immediate aviation commander will establish the date of medical incapacitation and impose the temporary medical suspension. Aircrew under temporary medical suspension may not be assigned flying/ATC duties or operate the flight controls of a military aircraft. As an exception, the flight surgeon may recommend by DA Form 4186 that the officer operate flight simulators, perform ground run-up procedures, and/or undergo an aeromedical consultation with in-flight evaluation. The immediate commander may remove the temporary medical suspension upon favorable recommendation by a flight surgeon on DA Form 4186.

The flight surgeon will recommend medical termination from aviation service (permanent medical suspension) if the term of temporary medical suspension has or is expected to exceed 365 days [Note: formerly 180 days; Assistant Secretary of Defense, 1994]. The flight surgeon will notify the immediate aviation commander by DA Form 4186 and forward an Aeromedical Summary to Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333.

#### Medical termination from aviation service

Medical termination from aviation service (permanent medical suspension) is required for permanent aeromedical disqualifications that are not likely to result in requalification without a waiver within 365 days [Note: formerly 180 days; Assistant Secretary of Defense, 1994]. Continuation of flying duties is authorized only by issuance of orders for an aeromedical waiver by an aviation service waiver authority.

The local flight surgeon will evaluate the aeromedical disqualification and make a preliminary determination of medical fitness for flying duty. The flight surgeon will recommend a medical termination from aviation service (permanent medical suspension) on DA Form 4186 and forward the notification to the immediate commander. The flight surgeon will prepare an Aeromedical Summary and forward to Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333.

The Commander, USAAMC, ATTN: MCXY-A, will make final recommendations to the aviation service waiver authority, recommend a date of medical incapacitation, and a final aeromedical disposition of:

1. Medical termination from aviation service, or;
2. Aeromedical waiver for continuation of aviation service with a permanent aeromedical disqualification, or;
3. Requalification without aeromedical disqualification, "For Information Only."

Aviation service waiver authority will establish the final date of medical incapacitation. They will publish an order establishing the date of medical termination from aviation service. The aircrew member will be referred to the appropriate authority for reclassification, rebranching, or Service separation. The health record will be sent back to the medical treatment facility of origin.

The Federal Aviation Administration (FAA) Federal Air Surgeon requires the Commander, USAAMC, to report all termination from aviation service actions. This may be done without the knowledge or consent of the aircrew member by federal law as an exception to the Privacy Act of 1974, as requested by the FAA in 1977 (5 USC 552a(b); Federal Aviation Administration, 1977).

#### Aeromedical waiver

In the case of permanent aeromedical disqualification, the aircrew member may request consideration for an aeromedical waiver for aviation service through a local military flight surgeon. The flight surgeon will complete an evaluation within the aeromedical standards of care following regulations and the policy letter series. The flight surgeon will prepare an aeromedical summary and forward to Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333.

The Chief, U.S. Army Aeromedical Consultation Service will review the case and arrange for additional evaluation by aeromedical consultants designated by Commander, USAAMC, as required. They are authorized to send the patient to U.S. Air Force or U.S. Navy aeromedical consultation services as required, or arrange for in-flight evaluations, as required (AR 600-105, Aviation services). Selected cases will be presented to the U.S. Army Aeromedical Consultant Advisory Panel.

The Director, U.S. Army Aeromedical Activity will formulate a consensus of aeromedical opinion on the medical fitness for flying duty for the Commander, USAAMC. The Director will determine if an aeromedical waiver can be recommended; and if so, determine if the waiver will require recommendations for specific restrictions in the flight environment and/or specific follow-up medical evaluations to maintain the waiver. Final recommendations will be forwarded through Commander, USAAMC, to the aviation service waiver authority.

The aviation service waiver authority will review the aeromedical recommendations and supportive enclosures, consider the needs of the U.S. Army, and make a final determination to grant or deny an aeromedical waiver. They will publish orders to permit continuation of aviation service with a waiver, or medical termination from aviation service (permanent medical suspension). The health record(s) will be sent back to the medical treatment facility of origin.

The aircrew member will acknowledge the waiver, and if applicable, restrictions and follow-up evaluation, in writing to the aviation service waiver authority. Failure to do so, or declining the waiver, will be considered a nonmedical disqualification due to dereliction of duty and may result in a flying evaluation board (AR 600-105, Aviation service).

The flight surgeon may recommend amendments to the conditions for continuation of waivers in effect, as required, by submitting written justification along with supportive documents to the Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333. If the condition resolves or is no longer disqualifying due to policy and standards changes, the flight surgeon may recommend revocation of an aeromedical disqualification to the Commander, USAAMC.

## Aeromedical requalification with or without a waiver

An aircrew member with a medical termination from aviation service may request aeromedical requalification if the medical disqualification resolves or improves. The procedure for requesting requalification is the same as the procedure for aeromedical waiver, except the aviation service waiver authority will determine if requalification meets the needs of the Army, and if so, publish orders establishing date of the aeromedical requalification, publish orders of assignment and travel, and issue an administrative waiver if required.

### Review and disposition of disqualifications for civilian Class 2/3/4

#### General principles for Class 2 civilian aviators

DA owns and operates "public use" aircraft, rather than private or commercial aircraft. The Federal Air Surgeon directed that the agency (in our case, the Department of the Army) that owns and operates public use aircraft is responsible for the medical certification of aircrew members operating these aircraft. Possession of a current Federal Aviation Administration (FAA) medical certification (FAA "medical ticket", FAA Form 8420-2) is not required for aircrew members to fly public use aircraft owned or leased by DA. Despite this, some contractor companies unilaterally require their employee aircrew members to possess a valid FAA medical certification, in addition to Army medical certification. DA may grant civilians the privilege, rather than the right, to fly DA aircraft based upon meeting medical certification and flight qualification requirements established by DA. Flying DA aircraft is considered an arduous or hazardous duty because the aircrew member's medical condition may adversely influence the safe and effective completion of aviation duties, and the aviation operational environment may adversely impact on the medical condition of the aircrew member. TSG has the authority and responsibility to determine the medical fitness for flying duty of all DAC and DA contract civilian aircrew members flying in aircraft that are owned or leased by DA (5 CFR 339.202, 203, 205, and 301; and AR 95-20). TSG conducts an aviation medicine program (medical evaluation program) for the medical certification of civilian aircrew members and designates the examining medical care professional when they order or offer an examination (5 CFR 339.303). TSG may order psychiatric evaluation of civilian aircrew members when actions or behavior result in performance or conduct problems on the job (5 CFR 339.301).

The minimum standards guidelines for the initial consideration of hiring DAC pilots are U.S. Army Class 2 standards as per chapter 4, AR 40-501. Subsequent determination of medical fitness for flying DA aircraft will be conducted by DA as outlined in chapter 6, AR 40-501. The job description will state that DAC pilots will maintain a current Army Class 2 medical certification.

Chief, U.S. Army Aviation Branch, Commander, U.S. Army Safety Center, and Commander, USAAMC have determined the initial and subsequent determinations of medical fitness for DA contract civilian pilots flying aircraft owned or leased by DA are made as per chapter 4, AR 40-501, and AR 95-20. Subsequent determination of medical fitness for flying DA aircraft will be conducted by DA as outlined in chapter 6, AR 40-501. The contract will state that DA contract civilian pilots will maintain a current Army Class 2 medical certification.

These special provisions apply to all civilian aviators. Civilian pilots are not required to meet the requirements of the Army Weight Control Program. Maximum allowable body weight and anthropometrics will be that which does not prevent normal function required for safe and effective aircraft flight, to include interference with aircraft instruments and controls. Minimum body size, weight, and physical strength will be that which allows safe and effective flight in Army aircraft to include proper function of ejection seats, crashworthy seats, restraints system, and other safety equipment. The local flight surgeon will prepare an aeromedical summary with recommendations, as required, and refer these cases to Commander, USAAMC, for final determination.

#### General principles for Class 3 civilians

Civilian aircrew members who perform regular duties in DA aircraft in flight, but do not operate aircraft flight controls, will be evaluated under Army Class 3 medical fitness standards by a military flight surgeon who makes the determination of fitness for flying duties. Waivers and suspensions are granted or denied by the responsible waiver authority, generally the Command Aviation Officer. Questionable cases will be referred to USAAMC for consultation and review.

#### General principles for Class 4 civilian ATCs

In 1987, the FAA delegated the authority to medically certify ATCs working in Department of Defense facilities to the agency operating the facility, in our case, the DA (14 CFR 65). This directive includes DAC and contract civilian ATCs. Controlling air traffic is considered an arduous or hazardous duty because the ATC medical condition may adversely effect the safe and effective control of aircraft traffic creating a public safety hazard. TSG has the authority and responsibility to determine the medical fitness for ATC duty of all DAC and DA contract ATC working in DA facilities (5 CFR 339.202, 203, 205, and 301; 14 CFR 65.31, 33; and AR 95-20). TSG conducts an aviation medicine program (medical evaluation program) for the medical certification of ATCs and designates the examining medical care professional when they order or offer an examination (5 CFR 339.303). TSG may order psychiatric evaluation of ATCs when actions or behavior result in performance or conduct problems on the job (5 CFR 339.301).

#### Review and disposition of civilian aircrew members and ATCs

The Army Aviation Medicine Program will conduct FDMs on all DAC and DA contract civilian aircrew members and ATC on initial hire, and then annually within 90 days before the last day of their birth month, to determine if they meet Army medical standards of fitness for flying duties (Classes 2/3/4). Any military flight surgeon may conduct the examination. Additional interim examinations are required if a civilian aircrew member/ATC develops a change in health that may affect the status of the medical certification. The aircrew member/ATC is required to report interim changes in health to the FS. DA obligation to pay for medical examinations, tests, or consultations is only to the extent required to determine if the civilian is medically qualified. Once medically disqualified, subsequent medical examinations, tests, or consultations that may be required by DA for waiver consideration are the financial responsibility of the disqualified civilian unless the civilian is eligible for DOD health care delivery (AR 40-3).

If the attending military flight surgeon finds the civilian aircrew member/ATC qualified under Army medical fitness standards, the flight surgeon will issue the status of "full flying duties" (FFD) on a DA Form 4186 (Medical Recommendation for Flying Duty), valid until the last day of the next birth month. The flight surgeon will forward the Class 2 and 4 FDMEs to Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333 for central review and verification of medical fitness.

If the attending military flight surgeon finds the civilian aircrew member/ATC disqualified under Army medical fitness standards, the flight surgeon will issue the status of "duties not to include flying" (DNIF) on DA Form 4186. In certain circumstances outlined in the Army APL series or upon direct approval by the U.S. Army Aeromedical Consultation Service (AMCS), USAAMC, the status of "temporary FFD pending receipt of waiver" may be issued on DA Form 4186. The flight surgeon will prepare and forward an Aeromedical Summary of the medical disqualification to USAAMC for central review and verification of medical fitness. If the disqualified civilian desires a consideration for aeromedical waiver of the medical disqualification, the local flight surgeon or USAAMC may direct additional medical examinations, tests, or consultations by DA-designated health care providers and institutions to evaluate the disqualifying medical condition. Civilians may submit additional medical documents from health care providers or institutions of their choice. USAAMC will make a final determination of medical fitness for flying duties, recommending a waiver of the medical disqualification or suspension from flying duties to the designated waiver authority. USAAMC may seek additional aeromedical consultation from DA-designated aeromedical consultants or the Army Aeromedical Consultant Advisory Panel (ACAP), as required. USAAMC's final disposition recommendation will take into consideration the civilian's medical condition, aircraft flown, mission and duties, and deployability status. Medical disqualification of "preference eligible" DAC applicants are forwarded by the waiver authority to the Office of Personnel Management (OPM) for review.

The waiver authority will grant or deny the recommendation for aeromedical waiver or suspension from flying/ATC duties. Appendix J lists the waiver authorities for civilians. If the waiver authority grants suspension from flying duties, the disposition will be as follows:

1. DAC aircrew members/ATCs. The suspended DAC will be referred by the supervisor aviation unit commander to the Civilian Personnel Office for assistance in reassignment or reclassification to other duties not including flying/ATC. OPM will make the final determination of eligibility for medical disability.

2. DA contract civilian aircrew members/ATCs. The suspended DA contract civilian will be referred by the DA Contract Representative Officer to contractor management for reassignment to duties not to include flying/ATC or termination of employment.



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## Appendix A.

### Aeromedical terms and abbreviations

The terms aviation service, flying status, flight status, flying duty(ies) are interchangeable. The terms aircrew and aircrew member are interchangeable, and refer to personnel who are in or graduated from aviation, aviation medicine, or air traffic control training programs.

**Aeromedical standard of care** is the minimum level by which a flight surgeon conducts a comprehensive aviation medicine program to conserve aircrew health maintenance, flight safety, and operational readiness. The basis of the standard is promulgated by TSG through Army regulations, aeromedical policy letters, and aeromedical technical bulletins.

**Aviation training programs** are military courses of instruction that prepare personnel to perform rated or nonrated flying duties, or air traffic control (ATC) duties.

**U.S. military (DOD uniformed) flight surgeon (FS)** is a physician awarded the aeronautical designation of Flight Surgeon after graduation from a basic course in U.S. military aviation medicine. The term flight surgeon is interchangeable with aviation medicine officer.

**Aerospace Medicine Specialist** is a FS who successfully completed a Residency in Aerospace Medicine (RAM), or equivalent, as determined by the American Board of Preventive Medicine or TSG.

**Aeromedical Physician's Assistant (APA)** is a physician assistant who successfully completed a primary course of instruction in aviation medicine.

**Aeromedical Consultant Advisory Panel (ACAP)** is a panel of rated aviators designated by Commander, U.S. Army Aviation Center, and RAMs/FSs with multiple medical specialty credentials designated by the Commander, USAAMC, to include representatives from the U.S. Army Safety Center and the U.S. Army Aeromedical Research Laboratory.

**Aeromedical summary** is a specially formatted medical evaluation containing medical history, physical, and supportive documents prepared by a FS and forwarded to USAAMC for making a final determination of medical fitness for flying duties.

**Aeromedical disqualification (DQ)** is a medical condition that is defined in Chapters 2 and 4 of Army Regulation 40-501, Medical fitness standards, as unfitting for aviation or ATC duties. Army Regulation 600-105, Aviation service, contains definitions and procedures for temporary medical suspension, medical termination of aviation service, aeromedical waivers, and return to aviation service after termination of aviation service. Army Regulation 600-105 defines procedures for non-medical disqualifications for aviation service, flying evaluation boards (FEB), and in-flight aeromedical evaluations.

**Temporary aeromedical DQ** is a failure to meet a standard of medical fitness for flying duties due to a minor, self-limited condition that is likely to resolve and result in requalification within 180 days. A temporary aeromedical DQ will automatically become a permanent aeromedical DQ if the condition persists for more than 365 days (formerly 180 days).

**Permanent aeromedical DQ** is a failure to meet a standard of medical fitness for flying duties due to a condition that will require a waiver for continuation of aviation service, or result in medical termination of aviation service.

**Full flying duties (FFD)** is a recommendation of medical fitness permitting flying or ATC duties as annotated by a FS on DA Form 4186.

**Duties not to include flying (DNIF)** is a recommendation of medical unfitness prohibiting flying or ATC duties as annotated by a FS on DA Form 4186.

**Date of medical incapacitation** is the date a disqualifying medical condition was definitively diagnosed by history, examination, or test. The effective date of medical termination from aviation service is based on this date. This date may not always correspond with the date of DNIF issued by the local flight surgeon on DA Form 4186.

## Appendix B.

Table B-1.  
AEDR medical classification and purpose of examination codes.

Class	AEDR code	Purpose of examination
1	1W RW	Initial FDME, Warrant Officer aviator applicant Fort Rucker Abbreviated Class 1 FDME
1A	1A RO	Initial FDME, Commissioned Officer aviator applicant Fort Rucker Abbreviated Class 1A FDME
2	AI AA AB RA	Initial FDME, aviator Comprehensive FDME, aviator Interim FDME, aviator Fort Rucker interim examination of student aviator
2F	FI FA FB	Initial FDME, flight surgeon Comprehensive FDME, flight surgeon Interim FDME, flight surgeon
2F	PI PA PB	Initial FDME, aeromedical physician assistant Comprehensive FDME, aeromedical physician assistant Interim FDME, aeromedical physician assistant
2S	OI OA OB	Initial FDME, aeroscout observer or aerial fire support observer Comprehensive FDME, aeroscout observer or aerial fire support observer Interim FDME, aeroscout observer or aerial fire support observer
3	CI CA CB	Initial FDME, non-rated aircrew member Comprehensive FDME, non-rated aircrew member Interim FDME, non-rated aircrew member
4	TI TA TB TC	Initial FDME, air traffic controller, military and civilian Comprehensive FDME, air traffic controller, military and civilian Interim FDME, air traffic controller, military and civilian Civilian air traffic controller (old code, replaced by TI, TA, and TB)
	NA NM	NASA applicant, Class 1, pilot astronaut NASA applicant, Class 2, mission specialist

### AEDR status codes

Table B-2 lists and describes AEDR status codes used by USAAMA, grouped by categories of use. AEDR status codes are placed in the AEDR flight physical database, AEDR waiver and suspense file, and on flight physical and aeromedical summary documents. The codes are useful in quickly communicating the status of USAAMA reviews when patients and flight surgeons make USAAMA inquiries. AEDR analysts use AEDR codes to monitor productivity and for indexing data searches. The codes are dynamic, and each patient encounter may have different codes at different stages of processing the action through USAAMA and waiver authorities before a final code is determined. Sometimes a code may be placed on a FDME, and the code is later superseded by a code placed on an aeromedical summary that may have been processed at a later date than the FDME. Older FDMEs may be marked with codes no longer used by USAAMA. In rare cases, the codes may be placed erroneously on the record, in which case, the flight surgeon needs to call USAAMA for verification of the final disposition, COMM (334) 255-7430 or DSN 558-7430.

Table B-2.  
AEDR status codes.

Category	Code	Description
Qualified	QU	QUalified
	QS	Qualified with Spectacle wear inflight
	QI	Qualified Information only following review by USAAMA
	QA	Qualified at Ft. Rucker after flight student Anthropometry evaluation
Disqualified	DQ	DisQUalified for failure to meet medical fitness standards
	DI	Disqualified, returned Incomplete for more information
	DN	Disqualified, returned 1 year ago, and New FDME received
Waiver	WR	Waiver Recommended by USAAMA
	WG	Waiver Granted by waiver granting authority at PERSCOM or NGB
	WC	Waiver Continued following review by USAAMA
	WT	Waiver, Temporary (occasionally used in special circumstances, such as Desert Storm operations, pending complete evaluation at later date)
Waiver amendment	AR	Amendment to waiver Recommended by USAAMA
	AG	Amendment to waiver Granted by waiver authorities
	AD	Amendment to waiver Denied by waiver authorities (rare event)
Suspension (Termination of aviation service)	SR	Suspension (medical termination) Recommended by USAAMA
	SG	Suspension (medical termination) Granted by waiver authorities
	SC	Suspension (medical termination) Continued after repeat review

Note: Table B-2 is continued on the next page.

AEDR status codes.

Category	Code	Description
Medical elimination	ME	Medical Elimination from flight training, unspecified
	MN	Medical elimination from aviator WOC school, Nonenrolled in flying
	MR	Medical elimination from flight training after enRolled in flying duties
	MO	Medical elimination of trained aviator (Officer) from a flight course
	MT	Medical elimination from air Traffic control training
Exceptions to policy	ER	Exception to policy Recommended by USAAMA
	EN	Exception to policy Not recommended by USAAMA
	EG	Exception to policy Granted by waiver authorities
	ED	Exception to policy Denied by waiver authorities
	EC	Exception to policy Continued
Deceased	DA	Deceased due to hostile or nonhostile Aircraft mishap
	DO	Deceased due to Other than aircraft mishap
USAAMA administration	RC	Sent by USAAMA for Recommended specialty Consultation
	AF	Sent to Brooks Air Force Aeromedical Consultation Service
	AS	FDME received with Aeromedical Summary
	ZZ	FDME arrived at USAAMA and logged into mailroom
	E1	First AEDR FDME entry completed
	E2	Second AEDR FDME entry completed for verification of first entry
	CK	Review by AEDR data entry staff completed, forwarded for final review by USAAMA physicians, USAAMA stamping, and mail out.
	FF	Review delayed by pulling prior records on Microx or laser optic
	RB	Returned FDME is Received Back for USAAMA review
	TD	Sent To AAMA Doctors for consultation
	TA	Sent To AAMA for key out
Old USAAMA codes	RT	ReTurned; now replaced by DI
	RN	Returned, Not received back after 1 year; now replaced by DN
	NU	Never Updated



## Appendix C

### Summary of initial and comprehensive FDME requirements by item number

Table C-1.

Summary of FDME requirements by item number, SF 88.

Medical standards class	1, 1A	2, 2F, 2S, 3, and 4	
Purpose of examination	All	Initial	Comprehensive
SF 88 item number			
1. Name	Y	Y	Y
2. Grade and component	Y	Y	Y
3. Social Security number	Y	Y	Y
5. FDME class and purpose	Y	Y	Y
6. Date of examination	Y	Y	Y
7. Gender (sex)	Y	Y	Y
8. Race	Y	Y	Y
10. Government agency	Y	Y	Y
12. Date of birth	Y	Y	Y
15. Exam facility and 5-digit code	Y	Y	Y
16. Exam facility phone/FAX	Y	Y	Y
17. Skill and flight hours	N	Y	Y
18.-43. Clinical examination	Y	Y	Y
23. Valsalva	Y	Y(1)	Y(1)
32. Digital rectal and stool guaiac	Y	Y	(2)
44. Dental examination	Y	Y	Y
45A. Urine specific gravity	N	N	N
45B. Urine albumin	Y	Y	Y
45C. Urine sugar	Y	Y	Y
45D. Urine dipstick/microscopic	Y	Y	Y
46. Chest X-ray	Y	Y	(3)
47. Serology test and result	Y	Y	(3)
48. Resting electrocardiogram	Y	Y	Y
49. DNA typing	(3)	(3)	(3)

Table C-1 (Continued).  
Summary of FDME requirements by item number, SF 88.

Medical standards class	1, 1A	2, 2F, 2S, 3, and 4	
Purpose of examination	All	Initial	Comprehensive
SF 88 item number			
50. Other test results			
Hematocrit or hemoglobin	Y	Y	Y
Fasting blood sugar	Y	Y	(2,3)
Total cholesterol	Y	(4)	(4)
HDL cholesterol	Y	(4)	(4)
Triglycerides	Y	(4)	(4)
Sickledex	Y	Y(1)	N
HIV serology	Y	(3,7)	(3,7)
51. Height (inches)	Y	Y	Y
52. Weight (pounds)	Y	Y	Y
Percent body fat (AR600-9)	(5)	(1,5)	(1,5)
57A. Sitting blood pressure	Y	Y	Y
57B-C Other blood pressures	N	N	N
58A. Sitting pulse	Y	Y	Y
58B-C. Other pulses	N	N	N
59. Distant vision	Y	Y	Y
60. Refractions			
Cycloplegic	Y	N	N
Manifest (glasses Rx)	N	(6)	(6)
61. Near vision	Y	Y	Y
62. Heterophoria			
Test used and distance	Y	Y	Y
Esophoria	Y	Y	Y
Exophoria	Y	Y	Y
Hyperphoria (right, left)	Y	Y	Y
Cover test (CT)	Y	Y	N
Near point convergence (NPC)	Y	Y	N
63. Accommodation	N	N	N
64. Color vision	Y	Y	N
65. Depth perception	Y	Y	Y
66. Field of vision	Y	Y	N
67. Night vision history	Y	Y	Y
68. Red lens test	N	N	N

Table C-1 (Continued).  
Summary of FDME requirements by item number, SF 88.

Medical standards class	1, 1A	2, 2F, 2S, 3, and 4	
Purpose of examination	All	Initial	Comprehensive
SF 88 item number			
69. Intraocular pressure	Y	Y	(2,3)
71. Audiometry	Y	Y	Y
72. Aeronautical adaptability	Y	Y	N
Reading aloud test	Y	Y	N
73. Notes			
AR 40-8 statement	N	Y	Y
Linear anthropometrics (cm)	Y	Y(1)	N
Cardiovascular disease screen	N	(4)	(4)
Cornea slit lamp examination	Y	Y	N
74. Summary of defects	Y	Y	Y
75. Recommendations	Y	Y	Y
76. Physical profile	Y	Y	Y
77. Qualification statement	Y	Y	Y
78. Disqualifying defects	Y	Y	Y
79-82. FLT SURG name/signature	Y	Y	Y
Accessory history forms to SF88			
SF93	Y	Y	Y
Aeromedical continuation-			
SF 93 History	Y	Y	N
SF 93 Allergic rhinitis	Y	Y	N
SF 93 Alcohol	Y	Y	N
SF 93 Drugs	Y	Y	N

Notes:

- (1) Not required for Class 4 (Air Traffic Control).
- (2) Required age 40 and older.
- (3) Required if medically indicated or required by the U.S. Army PrevMed program.
- (4) Required as per Aeromedical Policy Letter 28.
- (5) Required when weight exceeds AR 600-9 weight tables.
- (6) Required if unaided near/distant vision is not 20/20.
- (7) HIV testing in civilian aircrew members is voluntary, not required.

## Appendix D

### AEDR data entry guidelines for Standard Form 88.

This appendix outlines the aeromedical standard of care for DOD Standard Form 88 data entry by item number.

#### **1. Name.**

Enter: Enter the last name, first name, and middle initial.

Notes: If the individual's first name consists of an initial only, indicate by adding "(IO)" after the name. Place "Jr." or similar designations after the middle initial. If there is no middle name or initial, put a dash after the first name.

Examples:

Rockford, Clarence K, Jr.  
Bell, J T (IO)

#### **2. Grade and component.**

Enter: Enter the grade (O4, E7) or rank (MAJ, SFC).

Enter: Enter the component from the choices below:

##### Active duty force:

Regular Army, active duty	RA
Army Reserve, active duty	USAR-AD
Army Reserve, AGR	USAR-AGR
Army National Guard, AGR	ARNG-AGR

##### Reserve duty force:

Army Reserve, reserve duty or ADT	USAR
Individual Ready Reserve	IRR
Army National Guard	ARNG

##### Other:

Warrant Officer candidate	WOC
Military Academy cadet	USMA
Army ROTC cadet	ROTC
Army NASA applicant	NASA
Department of Army civilian	DAC
Reserve component civilian technician	DAC with military rank
Contract civilian	CIV
Army retired	RET
No military affiliation	CIV

Notes: Enter components for dual status individuals, such as USAR/DAC, ARNG/DAC, DAC/RET, CIV/RET.

### **3. Identification number.**

Enter: Enter the individual's Social Security number (SSN).

### **4. Home address.**

Enter: Individual's current home mailing address. If the individual is in transit due to PCS or deployment, enter the best known forwarding address and attach a copy of the movement orders.

### **5. Purpose of examination.**

Enter: Enter the aircrew member's duty position.

Examples:

Aviator  
Flight surgeon (FS) or Aeromedical physician assistant (APA)  
Aeroscout observer (AO)  
Air traffic controller (ATC)  
Crew chief  
Flight medic

Enter: Enter the purpose of examination from the list below:

Initial FDME or repeat initial FDME  
Abbreviated Fort Rucker Class 1W (RW)  
Abbreviated Fort Rucker Class 1A (RO)  
Comprehensive FDME  
Interim FDME

Enter: Enter the class of medical standards applied to the individual from the choices below:

Class 1W Warrant Officer flight training applicant  
Class 1A Commissioned Officer flight training applicant  
Class 2 Aviator  
Class 2F Flight Surgeon/Aeromedical physician assistant  
Class 2S Aeroscout observer (MOS 93B)  
Class 3 Non-rated aircrew; crew chief, etc.  
Class 4 Air traffic control

Examples:

ROTC cadet, Initial, Class 1A  
Aviator, Interim, Class 2  
Aviator, Comprehensive, Class 2

**6. Date of examination.**

Enter: Enter the FDME date. Record in military style with day, month, year.

Example: 10 SEP 92

**7. Gender.**

Enter: Enter the gender from the choices below:

Male  
Female

**8. Race.**

Enter: Enter the race from the choices below:

Caucasian  
Black  
Oriental  
Other

**9. Years of Government service.**

Enter: Record the years of active/reserve military service.

Enter: Record the years of civilian service for the military.

**10. Agency.**

Enter: Enter the branch of military service or civilian agency. Caution- do not confuse with the service component.

Examples:

DA (Department of Army)  
DAF (Department of Air Force)

**11. Unit.**

Enter: Enter the individual's unit name, address, and telephone number.

**12. Date of birth.**

Enter: Enter the date of birth. Record in military style with day, month, year.

Example: 25 MAR 51

**13. Place of birth.** Optional: not required.

**14. Next of kin.**

Enter: Enter the name, address, and relationship of the person to be notified in the event of an emergency.

**15. Place of exam.**

Enter: Enter the examination facility five-digit AEDR code number.

Enter: Enter the name and address of the examining facility or examiner.

**16. Other information.** Enter exam facility telephone number and FAX number.

**17. Rating specialty.**

Enter: Individual's current military job or specialty by title and SSI.

Enter: Record the total years in this capacity.

Enter: If aviator, enter their current aircraft and career flying hours.

Examples:

Aeroscout 93B 2.6 years 185 hrs

Flight Surgeon 61N9D 3.5 years 300 hrs

Aviator 15G 10 years CH-47 1,450 hrs

**18-43. Clinical examination.**

Enter: Record each abnormal examination finding. The record must be legible, concise, and complete, permitting appraisal of its aeromedical significance. If additional space is required, describe the condition on Standard Form 600. Attach supporting documents such as X-ray reports, laboratory findings, and consultations. Prepare an aeromedical summary, if required, and place on top of the FDME (see also ATB 3 and ATB 4). Preprinted or stamped responses are acceptable only if they require a written indication or a choice (circle or check) on the part of the examiner.

Example: 29- Grade II/VI functional SEM, echocardiogram normal, report attached.

### **23. Eardrums.**

Enter: Enter all abnormal findings such as scarring, perforation, etc. Examine the tympanic membrane for normal free movement while the examinee performs a valsalva maneuver. The results are entered from the choices below:

Valsalva normal AU  
Valsalva abnormal  
Valsalva not done

Example: Valsalva NL\_\_\_ ABN X Not done\_\_\_ Left TM is immobile, see attached ENT consult and aeromedical summary.

### **32. Digital rectal examination and stool guaiac test.**

Enter: Digital rectal is required on initial FDME's (all ages), on comprehensive and interim FDME's (age 40 and over), or when medically indicated. Record abnormalities in the clinical evaluation notes section. If disqualifying, summarize in Item 74 and prepare an aeromedical summary. The results of the digital rectal examination are entered from the choices below:

Normal  
Abnormal, describe defect  
Not Done

Enter: Stool guaiac test (hemoccult test) is required with all digital rectal examinations. If the test is positive, annotate the evaluation used to find the cause of the positive test in Item 73. If the underlying cause is disqualifying, summarize the diagnosis in Item 74 and prepare an aeromedical summary. The results are entered from the choices below:

Positive  
Negative  
Not Done

Example:

Rectal NL\_\_\_ ABN X Not done\_\_\_  
Guaiac NEG X POS\_\_\_ Not done\_\_\_  
0.5 cm hard nodule, left prostate, aeromedical summary attached.

### **39. Body marks.**

Enter: Describe identifying surgical scars, body marks, or tattoos.

### **43. Pap smears, pelvic and breast examinations, and mammograms for females.**

Notes: Pap smear, pelvic and breast examinations are required on all FDMEs for females. Mammography is required on all FDMEs at age 40, 42, 44, 46, 48, 50, and then annually. Mammography may be performed in other years if medically indicated. The results of these



examinations may be transcribed from official records if done within 6 months of initial FDMEs and within 15 months of comprehensive FDMEs.

Enter: Enter the Papanicolaou smear date and test results in the clinical evaluation notes section of SF 88, page 1. Attach copies of abnormal Pap smear results and gynecological consultation to the FDME.

Enter: Enter the date and findings of the pelvic and breast examinations in the clinical evaluation notes section of SF 88, page 1. Attach copies of abnormal pelvic or breast examination findings and gynecological consultation to the FDME.

Enter: Enter the date and findings of the mammogram in Item 73. Attach copies of abnormal mammography reports with gynecological and/or surgical consultation to the FDME.

#### **44. Dental.**

Enter: Enter the DOD dental classification code, if known; or "acceptable" or "unacceptable." Assess the examinee's dental health with respect to hygiene, speech, proper wear of life support equipment, and deployability. Examining dental officers, when available, complete item 44, determine the classification, and sign the Standard Form 88 in Item 79-82.

#### **45. Urine.**

Enter: The urine specific gravity is not required on any FDME.

Enter: Record the dipstick urine albumin results in Item 45B on all initial and comprehensive FDMEs. Urine albumin is not required on interim FDMEs. If the urine albumin is trace or greater, record a 24-hour urine for protein in mg per 24 hours and creatinine clearance in Item 73.

Enter: Record the dipstick urine glucose results in Item 45C on all initial and comprehensive FDMEs. Urine glucose is not required on interim FDMEs. The urine glucose is abnormal if the result is trace or greater. If abnormal, record the results of fasting serum glucose, 2-hour post prandial serum glucose, and hemoglobin A1C tests in Item 73.

Enter: Record microscopic or dipstick results for red and white blood cells in Item 45D.

Normal ranges:

45B. Albumin	Negative
45C. Sugar	Negative
45D. Microscopic	0-5 RBC, 0-5 WBC, 0-trace bacteria, no casts
Dipstick	Negative RBC
	Negative WBC

#### **46. Chest X-ray.**

Enter: Enter the place, date, and findings. A chest X-ray is required on all initial FDME's. If the chest x-ray was performed in the previous 12 months, the results may be transcribed from official records. A chest X-ray is not required on all other examinations unless clinically indicated.

Example: RACH, Ft. Sill, 03 Mar 93, normal, Film# 93-2316.

#### **47. Serology.**

Enter: Serology is required on all initial FDME's. Serology is not required on comprehensive or interim FDME's unless clinically indicated. Complete a FTA-ABS if the VDRL or RPR are positive. Enter the name of the test from the choices below:

VDRL  
RPR  
FTA-ABS

Enter: Enter the test results from the choices below:

Negative  
Positive, and if positive, record titer and FTA-ABS titer.

#### **48. Fasting 12 lead electrocardiogram at rest.**

Enter: Electrocardiograms are required on all initial FDMEs, and beginning at age 34 on all comprehensive FDMEs.

Enter: Record the interpretation of any normal variant or abnormal electrocardiogram in Item 73. Use APL 2 as a reference for preferred terminology in stating the aeromedical interpretation. Provide original tracings, properly mounted and identified on SF 520. A physician's interpretation and signature is required on all SF 520 and/or original ECG's. Compare this ECG with previous ECG's in the patient record, and annotate changes, if present, in Item 73; and forward copies of the previous, different tracings for review along with the FDME. Additional tests for abnormal ECG's may be required by APL 2. Submit the results of these tests and original tracings along with the FDME, or if required, aeromedical summary.

Enter: Summarize the results of the electrocardiogram in Item 48 from the choices below:

Normal, G700  
Normal variant, see item 73  
Abnormal, see item 73

Examples in item 73:

1st degree AV block, resolves HR>100, normal variant.  
Left axis deviation, -60 degrees, abnormal.  
Multiform PVC's, abnormal, 15% of total beats, see attached 24 hour Holter monitor tracings and report.

**49. Blood and DNA typing.** These are not required for the AEDR, but flight surgeons must ensure that the aviator or training applicant has complied with the requirements of the Army blood typing and DNA typing programs. The results must be on file in the outpatient medical record.

**50. Other laboratory tests.**

**Hematocrit or hemoglobin.**

Enter: Enter the value as "%" for hematocrit and "gm/100cc" for hemoglobin.

Normal ranges:

	Hematocrit	Hemoglobin
Male:	40% - 52%	14 - 18 gm/100cc
Female:	37% - 47%	12 - 16 gm/100cc

**Cholesterol and HDL-cholesterol, 14 hour fast.**

Enter: Enter the value as "mg%".

Notes: Perform the cardiovascular risk assessment as per APL 28. Attach results and tracings of secondary coronary artery disease screening, if required, and summarize results in Item 73. Note if dietary consultation was initiated in Item 73. If the values are abnormal clinically or the aviator fails Level 1 cardiovascular disease screening, repeat the cholesterol and HDL-cholesterol tests two more times, and record the results in Item 73. Take the values of all three cholesterol and HDL-cholesterol tests and average them for USAAMA staff in Item 73.

**Fasting blood sugar.**

Enter: Enter the value as "mg%".

Notes: If greater than 115 mg%, do repeat FBS and 2-hour post prandial glucose after a 75 gram glucose load. Follow guidelines in APL 16. If less than 50 mg%, evaluate the patient for hypoglycemia, and if clinically indicated glucose tolerance testing.

**Sickle Cell screen.**

Enter: Sickle cell screening is required on all initial FDMEs. If positive, annotate results of a hemoglobin electrophoresis in Item 73. Results may be transcribed from official records. Enter the test results from the choices below:

Negative  
Positive

### **HIV testing.**

Enter: HIV testing is required every 2 years, or as required by changes in Army Preventive Medicine Program policy. Submit staging evaluation results attached to an aeromedical summary if the HIV is positive. Enter the test results from the choices below:

HIV Negative

HIV Positive (Western Blot Confirmed)

HIV Positive (Western Blot Not Confirmed)

### **51. Height and linear anthropometrics.**

Enter: Record the standing height without shoes to the nearest whole inch. Standing height is required on all initial and comprehensive FDMEs.

Enter: Record the linear anthropometry findings to the nearest whole centimeter in Item 73. Linear anthropometry is required on all initial FDMEs. Measure the total arm reach (total arm span), sitting height, and inner leg length (crotch height) by the methods in Anthropometry ATB.

Example:

TAR 172 cm

SH 92 cm

LL 76 cm

### **52. Weight.**

Enter: Record the examinee's weight in summer PT uniform without shoes to the nearest whole pound. If the weight exceeds the Screening-Table weight for height and age, as listed in Army Regulation 600-9, Table 1, record the examinee's percent body fat in Item 73, and attach the percent body fat worksheet to the FDME.

Notes: Maximum normal ranges for percent body fat (AR 600-9):

Age	Male	Female
17 - 20	20 %	30 %
21 - 27	22 %	32 %
28 - 39	24 %	34 %
40 & above	26 %	36 %

### **53. Hair color.**

Enter: Enter the hair color from the choices below:

Brown

Brunette

Black

Red

Blonde

Gray

**54. Eye color.**

Enter: Enter the eye color from the choices below:

Brown  
Black  
Blue  
Green  
Gray  
Hazel

**55. Build.** Not required on FDMEs.

**56. Temperature.** Not required on FDMEs.

**57. Blood pressure.**

57A. Enter: Sitting blood pressure is required on all FDMEs.

57B/C. Enter: Not required, unless indicated by abnormal history, examination, or findings in 57A (tilt test).

Normal blood pressure ranges:

Systolic - 90 - 139 mmHg  
- Diastolic - 60 - 89 mmHg

Notes: Obtain sitting A.M. and P.M. blood pressures for 3 days if the blood pressure is abnormal. Record the findings in Item 73. If the average blood pressure still exceeds standards, mark the FDME disqualified, refer to Aeromedical policy letter 3 for guidance in the evaluation and control of the examinee's hypertension, and submit an aeromedical summary with the FDME requesting a waiver when control of the hypertension is achieved. Recommend termination of aviation service if the hypertension cannot be controlled by waiverable medications within 180 days, or the hypertension has other significant complications such as hypertrophic cardiomyopathy.

**58. Pulse.**

58A. Sitting pulse is required on all FDMEs.

58B. Not required.

58C. Not required.

58D. Not required unless indicated by history or examination in Item 58A (tilt test).

58E. Not required unless indicated by history or examinations in Item 58A (tilt test).

Normal ranges: 50 - 100

## 59. Distant visual acuity.

Enter: Record the uncorrected distant visual acuity for each eye using the English Snellen Linear System (20/20). Record the number of errors on the best distant visual acuity line. If there is more than one error, record the next best Snellen line.

Enter: If the uncorrected visual acuity of either eye is worse than 20/20, enter the corrected distant visual acuity for each eye. Record the manifest refraction in Item 60. If a cycloplegic refraction is required (Class 1 and Class 1A), enter the cycloplegic refraction instead of the manifest refraction.

### Examples:

20/20	(20/20 with no errors on the 20/20 line)
20/20 -1	(20/20 with one error on the 20/20 line)
20/30 corr 20/20	(20/30 corrected to 20/20)

Note: Enter 20/20 -2 as 20/25 since there is more than one error on the 20/20 line.

## 60. Refraction.

Enter: For each eye, enter the manifest or cycloplegic refraction as required. Enter the type of refraction as "manifest" or "cycloplegic" above the refraction values. Enter the spherical component and the cylindrical component prefaced by "+" or "-" signs. "Plano" or "0" may be used to indicate a spherical or cylindrical values of "0". Enter the cylinder axis.

Notes: If the individual requires corrective lenses, enter the current manifest refraction (when cycloplegic refraction not required).

Notes: Cycloplegic refraction is required for all initial Class 1/1A FDMes. The standardized aeromedical cycloplegic examination method is (see also ATB 5):

1. One drop topical ophthalmologic anesthetic to each eye.
2. One drop 1% Cyclogel to each eye, wait 5 minutes.
3. Repeat one drop 1% Cyclogel to each eye, wait 45 minutes.
4. Perform on objective cycloplegic refraction with a retinoscope or subjective refraction with phoropter. Auto-refractions are not permitted.

Notes: On Class 1 and 1A FDMes, the examiner must perform a transposition of the cycloplegic refraction since an error in excess of standards in any meridian is disqualifying. The method of transposition to the other major meridian is:

1. Add the spherical (S) and cylindrical (CX) components.  
This is the new transposed spherical component.
2. Reverse the sign of the original cylindrical component.  
This is the new transposed cylindrical component.
3. Change the cylinder axis by 90 degrees.  
This is the new transposed axis.

**Example:**

Before transposition:

OD	-0.25 S	-0.50 CX	045	Appears qualified
OS	Plano S	+0.50 CX	085	Class 1

But after transposition:

OD	<b>-0.75 S</b>	+0.50 CX	135	Is actually disqualified
OS	+0.50 S	-0.50 CX	175	Class 1

## **61. Near visual acuity.**

Enter: Record the uncorrected near visual acuity for each eye using the English Snellen Linear System (20/20). Record the number of errors on the best near visual acuity line. If there is more than one error, record the next best line.

Enter: If the uncorrected near visual acuity of either eye is worse than 20/20, enter the corrected near visual acuity for each eye. Enter the "BY" add in diopters if a bifocal is required. Record the manifest refraction in Item 60. If a cycloplegic refraction is required (Class 1 and Class 1A), enter the cycloplegic refraction instead of the manifest refraction.

**Examples:**

20/20	(20/20 with no errors on the 20/20 line)
20/20 -1	(20/20 with one error on the 20/20 line)
20/30 corr 20/20	(20/30 corrected to 20/20)
20/40 corr 20/20 BY +1.00	(20/40 corrected with +1.00 bifocal)

Note: Enter 20/20 -2 as 20/25 since there is more than one error on the 20/20 line.

## **62. Ocular motility.**

### **Heterophoria.**

Enter: Record the results of heterophoria testing on all initial and comprehensive FDMs. Identify the test used, distance to the target, and test results. Record values for exo-, eso-, and hyperphorias in diopters. Prism divergence is not applicable.

Recommended test: Armed Forces vision testing apparatus (AFVTA), Titmus II, Optic 2300.

Acceptable tests: Maddox Rod.

### **Cover Test (CT).**

Enter: Record the results of the cover-uncover test and cross-cover (alternate cover) test. First perform the test in the neutral position at 16". Then perform the test at a distance in the five primary directions of gaze (neutral, left, right, up, and down).

Enter: If no movement of the eyes is noted, enter "ORTHO."

Enter: If movement of the eyes is noted, enter "ABN" and obtain an ophthalmology consultation (see also Aeromedical policy letter 8, Ocular motility).

### **Near Point of Convergence (NPC).**

Enter: Enter the NPC in millimeters and record the units used (mm).

## **63. Accommodation.** Not required on FDMEs.

## **64. Color vision.**

Enter: Record the results of color vision testing on all initial and comprehensive FDMEs. Enter test used, score (number missed over the maximum score), and pass or fail.

Recommended test: Pseudoisochromatic Plates (PIP), 14 test plates.

Acceptable test: Farnsworth Lantern (FALANT), 9 test light pairs.

Unacceptable tests: Identification of red/green, D-15 or FM-100 hue test, tower color test.

### **PIP.**

Enter: Record the PIP test score as number plates wrong over total number of plates.

Notes: View the PIP plates at normal reading distance under indirect sunlight or on a MacBeth Easel with a "sunlight" color/temperature light bulb. PIP plates fade over time and should be replaced. Regularly mix the order of the PIP plates.

Normal ranges: 0/14 to 4/14 (no more than four errors)

Examples:	PIP 2/14	Pass	(2 errors out of 14 plates)
	PIP 5/14	Fail	(6 errors out of 14 plates)

### **FALANT.**

Enter: Record the FALANT results in Item 73 if the examinee fails the PIP test. If there is one or more errors in the first presentation of 9 FALANT light pairs, repeat the test with a second presentation of 9 FALANT pairs and report the total number of errors over 18 presentations.

Normal ranges: 0/9, 0-2/18



Example:

FALANT 0/9 Pass (no errors with nine light pairs)

FALANT 1/18 Pass (there was one error in first nine light pairs, no errors in second nine light pairs)

FALANT 3/18 Fail (total of 3 errors with 18 light pairs)

## **65. Binocular depth perception acuity (stereopsis).**

Enter: Binocular depth perception acuity (stereopsis) testing is required on all FDMEs. Enter test used, score or seconds of arc, and pass or fail.

Enter: If the examinee requires corrective lenses for visual acuity correction, check "Corrected" if examinee is wearing glasses, otherwise check "Uncorrected."

Normal range: 40 seconds of arc or better.

Recommended test:

AFVTA (Armed Forces vision testing apparatus)

Titmus II, Optic 2300

Acceptable tests:

Verhoeff Stereometer

Randot Circles

Unacceptable tests:

- Titmus Stereo Fly

Randot Forms

### **AFVTA.**

Enter: Record the AFVTA binocular depth perception acuity (stereopsis) testing score. Circle row "A" is a demonstration row for subjects and does not test depth perception (see also Aeromedical technical bulletin 7, Depth perception testing).

Normal range: No error in rows "B," "C," or "D" on AFVTA.

Example: AFVTA B thru D Pass

AFVTA B thru C Fail

### **Verhoeff.**

Enter: Record the Verhoeff binocular depth perception acuity (stereopsis) testing score as number of errors over the total number of test bar presentations (see also Aeromedical technical bulletin 7, Depth perception).

Notes: The tester randomly presents each of the eight test bar presentations (four with the stereometer in the upright position, and four with the stereometer upside-down), covering the front of the device while switching presentations. To avoid monocular depth perception cues, the subject's chin is stabilized on a chin rest. The subject nose to test target distance must be 100 cm.

Normal range: No errors in any of the eight test bar presentations.

Examples:

Verhoeff 0/8 Pass

Verhoeff 1/8 Fail

### **Randot circles.**

Enter: Record the Randot circles binocular depth perception acuity (stereopsis) testing score as the best of ten test circle rows correctly identified.

Notes: View the Randot circles test plate at normal reading distance. Randot circles test plates fade over time, invalidating the test score. They may need replacement as often as every 12 months, depending on the degree of exposure to damaging ultraviolet light. During the fading process, the plates turn from whitish gray background color to brownish gray background color. The circle margins become less sharp.

Normal range:

Correctly identifies all test circle rows in rows 1 through 8 (equals 40 seconds of arc or better).

Examples:

Randot 1 thru 10 Pass

Randot 1 thru 8 Pass

Randot 1 thru 7 Fail

### **66. Field of vision.**

Enter: Examination of the visual fields is required on all initial FDMes. Enter results of visual field "confrontation test". If the examination is normal to confrontation, enter "NTC." If abnormal enter "ABN", record the results in Item 73, and attach an ophthalmology consultation.

### **67. Night vision.**

Enter: Enter "NIBH" (not indicated by history) if no history of night vision deficiency is found.

Enter: Enter "ABN" (abnormal) if a history of night vision deficiency is found or suspected. Attach an ophthalmology consultation to the FDME. Night vision deficiencies may include blurring of vision despite 20/20 vision in daylight or inaccurate color discrimination despite normal color discrimination in daylight. The most common cause of an abnormal night vision history in Army aircrew members is night myopia that is usually correctable with refractive correction. Exclude retinopathy and ocular hypertension.

**68. Red lens test.** Not required on FDMEs, unless clinically indicated.

**69. Intraocular tension.**

Enter: Measurement of the intraocular tension is required on initial FDME's and all FDMEs beginning at age 40 and older. Record the intraocular tension for each eye in mmHg (OD=right and OS=left).

Acceptable tests:

Non-contact tonometry (NCT)  
Applanation tonometry.

Unacceptable test:

Palpation

Normal ranges:

- Less than 24 in each eye,  
- Less than 4 mmHg difference between eyes.

Notes: If reading in either eye is 22 or greater but less than 24, repeat the readings in 7 days by applanation tonometry. Two measurements of 22 or above is abnormal, or a difference of 4 mm Hg between eyes, and requires an ophthalmology evaluation as per Aeromedical policy letter 6.

Examples:

NCT OD 12 / OS 14  
TA OD 17 / OS 17

**70. Hearing.** Not required (see Item 71).

**71. Audiometry.**

Enter: Using pure-tone testing procedures prescribed in TB MED 501, record the best hearing acuity for each ear in decibel units at the frequencies of 500 Hz, 1000 Hz, 2000 Hz, 3000 Hz, 4000 Hz, and 6000 Hz.

## 72. Psychological.

Enter: Enter the flight surgeon's assessment of the Aeronautic Adaptability (AA) examination, formerly called Adaptability Rating for Military Aeronautics (ARMA) before 1994.

Enter: Enter the results of the Reading aloud test (RAT, see Appendix L).

Enter: The finding of the AA and RAT examinations is either SAT (satisfactory) or UNSAT (unsatisfactory).

Notes: The AA (formerly ARMA) and RAT are required for all initial FDME's. "AA Favorable" is acceptable for FDME's performed in USN facilities. If the AA is UNSAT (unsatisfactory), document the reasons in Item 73, and attach any supportive documents or specialty consultations.

Examples:

AA SAT

AA UNSAT

RAT SAT

RAT UNSAT

## 73. Notes.

Enter: Record the results of corneal slit lamp examination on all Class 1/1A FDMEs and all initial Class 2/2F/2S FDMEs.

Enter: Record the smoking history in pack years.

Enter: Record Framingham Risk Index and cholesterol/HDL ratio if required by APL 28. IBM-PC risk calculator is available from Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362 (send 5.25 inch or 3.5 inch floppy).

Enter: Record notes on the examination, as necessary. Continue comments from other items in this space. List any previous waivers or suspensions and **provide results of any tests required to maintain the waiver.**

Notes: All FDME's (except Initial Class 1/1A) will contain the following statement which the examinee will read and sign:

"I understand I must be cleared by a flight surgeon after hospitalization or sick in quarters (AR 600-105, Aviation service); must inform him or her after treatment or activities which may require restriction (AR 40-8, Exogenous factors). I have read AR 40-8. I have informed the examining physician of any changes in my health since last examination."

#### **74. Summary of defects.**

Enter: Enter the item number followed by a short, concise diagnosis. Summarize aeromedically significant medical and dental defects, history, and use of medications.

#### **75. Recommendations.**

Enter: Enter recommendations for disposition, such as "Recommend waiver," "Recommend continuation of waiver," or "Recommend permanent disqualification." If there are no abnormalities enter "None." Enter appropriate statements such as "Spectacles must be worn whenever performing flying duty".

#### **76. Physical profile.**

Enter: For military aircrew, enter their current permanent profile status as prescribed by the PULHES system in AR 40-501.

Example:     P U L H E S  
              1 1 1 1 2 1

#### **77. Qualification.**

Enter: The flight surgeon enters a qualification statement and Class of aeromedical standards applied to the qualification statement.

Examples:     Qualified, Class 2S aeroscout  
                  Disqualified, Class 1A  
                  Qualified, Information Only, Class 2 aviator  
                  Qualified with waiver, Class 2 aviator

#### **78. Disqualifying defects.**

Enter: Record all disqualifying defects by item number.

#### **79-82. Physician, physician assistant, and dentist names.**

Enter: Enter typed or printed names of examiners, rank, corps, FS/APA designation, and Social Security number. Each examiner signs the FDME.

## Appendix E

### AEDR data entry guidelines for Standard Form 93.

This appendix outlines the aeromedical standard of care for DOD Standard Form 93 data entry by item number. For initial FDMes, Appendix M contains continuation SF 93 history forms that provide additional details required by USAAMA on general medical history, allergic rhinitis history, and historical use of alcohol and drugs. Use of these history continuation forms reduces the return rate for incomplete history.

1. **Name.** See SF 88, Item 1.
2. **Social Security number.** See SF 88, Item 3.
3. **Home address.** See SF 88, Item 4.
4. **Position.** See SF 88, Item 2.
5. **Purpose of examination.** See SF 88, Item 5.
6. **Date of examination.** See SF 88, Item 6.
7. **Exam facility.** See SF 88, Item 15.
8. **Statement of health.**

Enter: The examinee describes his or her current state of health, giving the history of any current problems, and the type, dosage, and interval of any medications routinely taken. If there are no current health problems, the examinee enters statements similar to the following:

"I am in good health."  
"I am taking no medications."  
"I have no medical waivers or profiles."

Enter: The examinee signs the statement of health.

## **9-12. Review of systems.**

Enter: The examinee responds to all questions. When the examinee does not understand a question, the examiner may explain, but not indicate what response should be entered. The examiner numbers all abnormal responses and refers to the numbers when making comments in Item 25.

## **13. Occupation.** See SF 88, Item 17.

## **14. Handedness.**

Enter: Enter "Right" or "Left" handed.

## **15-24. Past medical history.**

Enter: The examinee will answer all questions. Use the space on the right to elaborate on all "Yes" answers; to include the dates and locations of tests, treatments, and hospitalizations. Assist the examinee to obtain concise, but thorough entries. The examinee's name is printed or stamped on the left. The examinee signs their name on the right. The flight surgeon comments on responses in Item 25. Use DA Forms 4700, Continuation SF 93, from Appendix M, as required. Continuation SF 93, Medical history is required on all initial FDMEs.

## **25. Physician's summary.**

Enter: The examiner comments on all positive items in the medical history, Items 9-12, and Items 15-24. Describe the chronicity of the problem, residual impairment, and complications. Describe in greater detail conditions that are possibly disqualifying, the date of onset, and severity. Pay attention to positive items in the physical examination, and make specific comment on the SF 88 about range of motion, residual impairment, or loss of function. DA Form 4700, supplemental SF 93 history forms, for general history, allergic rhinitis, alcohol and drug use, and pregnancy are in Appendix M. A history of disqualifying medical problems requires an aeromedical summary.

Enter: Specifically note that direct questioning and response have been made about allergies, seizures, head injury, loss of consciousness, syncope, vertigo, motion sickness, contact lens wear, radial keratotomy, drug use, and family history of psychosis, seizures, diabetes, and heart disease (see Appendix M for form). The physical exam facility can place this information on the form in Item 12 by either an over-print or stamp which can be signed by the examinee.

Enter: The examiner prints or stamps their name, rank, and Social Security number on the bottom left, and signs their name at bottom right.

## Appendix F.

### AEDR data entry guidelines for DA Form 4497-R.

**Examination.** The interim FDME is recorded on DA Form 4497-R. It is required when an initial or comprehensive FDME is not required. The examination is based, in part, on the standard of care in age-specific public health screening examinations for asymptomatic individuals (U.S. Public Health Service, 1994). The examination protocol also is based on known Army aircrew member risk profiles for conditions that have been discovered by examination of asymptomatic aircrew members in the past. For example, the U.S. Public Health Service does not recommend routine screening of depth perception. However, in aircrew members, depth perception testing is a good screening test for overall ocular health, complementing visual acuity testing. The U.S. Public Health Service does not recommend adult hearing testing until age 65. Aircrew members are exposed occupationally to significant noise, resulting in our hearing conservation program with annual pure tone audiometry.

#### **1. Exam date.**

**Enter:** Enter the date of physician examination. Record in military style with day, month, year.

Example: 10 SEP 92

#### **2. Name.**

**Enter:** Enter the last name, first name, and middle initial.

**Notes:** If the individual's first name consists of an initial only, indicate by adding "(IO)" after the name. Place "Jr." or similar designations after the middle initial. If there is no middle name or initial, put a dash after the first name.

**Examples:**

Rockford, Clarence K.  
Longwood, Elliot T, Jr.  
Bell, J T (IO)

#### **3. Identification number.**

**Enter:** Enter the individual's Social Security number (SSN).

#### **4. Rank (Grade).**

**Enter:** Enter the rank (MAJ, SFC) or grade (O4, E7).



**5. Birth date.**

Enter: Enter the date of birth. Record in military style with day, month, year.

Example: 25 MAR 51

**6. Component of service.**

Circle: Circle the component from the choices below:

Active duty force

Regular Army, active duty	AD-RA
Active duty, USAR commission	AD-USAR
Army Reserve, AGR	USAR-AGR
Army National Guard, AGR	ARNG-AGR

Reserve duty force

Army Reserve, reserve duty	USAR-TPU
Individual Ready Reserve	USAR-IRR
Army National Guard	ARNG

Civilian force

Department of Army civilian	DAC
Reserve component civilian technician	DAC
Contract civilian	CIV Contractor
Army retired	RET-MIL

Notes: Circle applicable components for dual status individuals, such as USAR-TPU/DAC, ARNG/DAC, DAC/RET-MIL, CIV/RET-MIL.

**7. Circle the type of aircrew member duty performed.**

Enter: Circle the aircrew position.

Examples: Aviator  
Flight surgeon (FS)/aeromedical physician assistant (APA)  
Class 3 (Crew chief, flight medic, etc.)

**8. Unit of assignment and complete unit address.**

Enter: Enter the aircrew member's unit of assignment and the unit address.

**9. Unit phone number.**

Enter: Enter the aircrew member's unit phone number.

**10. Home phone number.**

Enter: Enter the aircrew member's home phone.

**11. List aeromedical waivers in effect.**

Enter: The aircrew member or flight surgeon lists the aeromedical waivers in effect by history review.

**12. List current medications and dosages.**

Enter: The aircrew member or flight surgeon lists the current medications used by the aircrew member.

**13. Medical clearance statement and patient signature.**

Note: Each FDME, the aircrew member traditionally reads and reaffirms their general responsibilities and exogenous factors guidelines under AR 40-8, Exogenous factors.

Enter: After reading AR 40-8 statement, the aircrew member signs the interim FDME.

**14 a, b, and c. Examination facility address, phone number, and AEDR code number.**

Enter: Enter the examination facility address, phone number, and 5-digit AEDR code number.

**15. Blood pressure.**

Enter: Sitting blood pressure is required on all FDMEs.

Normal blood pressure ranges:

Systolic - 90 - 139 mmHg

Diastolic - 60 - 89 mmHg

Notes: Obtain sitting A.M. and P.M. blood pressures for three days if the blood pressure is abnormal. Record the findings in Item 32. If the average blood pressure still exceeds standards, mark the FDME disqualified, refer to Aeromedical policy letter 3 for guidance in the evaluation and control of the examinee's hypertension, and submit an aeromedical summary with the FDME requesting a waiver when control of the hypertension is achieved. Recommend termination of aviation service if the hypertension cannot be controlled by waiverable medications within 180 days, or the hypertension has other significant complications such as hypertrophic cardiomyopathy.

## **16. Pulse.**

Enter: Sitting pulse is required on all FDMEs.

Normal ranges: 50 - 100

## **17. Height.**

Enter: Record the standing height without shoes to the nearest whole inch. Standing height is required on all initial and comprehensive FDMEs.

## **18/19. Weight and percent body fat.**

Enter: Record the examinee's weight in summer PT uniform without shoes to the nearest whole pound. If the weight exceeds the Screening-Table weight for height and age, as listed in Army Regulation 600-9, Table 1, record the examinee's percent body fat in Item 21, and attach the percent body fat worksheet to the FDME.

Notes: Maximum normal ranges for percent body fat (AR 600-9):

Age	Male	Female
17 - 20	20 %	30 %
21 - 27	22 %	32 %
28 - 39	24 %	34 %
40 & above	26 %	36 %

## **20 a, b, and c. Binocular depth perception acuity (stereopsis).**

Enter: Binocular depth perception acuity (stereopsis) testing is required on all FDMEs. Enter the test used, score or seconds of arc, and pass or fail.

Normal range: 40 seconds of arc or better.

Recommended test:

AFVTA (Armed Forces Vision Testing Apparatus)

Titmus II, Optic 2300

Acceptable tests:

Verhoeff stereometer

Randot circles

Unacceptable tests:

Titmus stereo fly

Randot forms

### **AFVTA.**

Enter: Record the AFVTA binocular depth perception acuity (stereopsis) testing score. Row "A" is a demonstration row for subjects and does not test depth perception (see also Aeromedical technical bulletin 7, Depth perception testing).

Normal range: No error in rows "B," "C," or "D" on AFVTA.

Example:

AFVTA B thru D Pass

AFVTA B thru C Fail

### **Verhoeff.**

Enter: Record the Verhoeff binocular depth perception acuity (stereopsis) testing score as number of errors over the total number of test bar presentations (see also Aeromedical technical bulletin 7, Depth perception).

Notes: The tester randomly presents each of the eight test bar presentations (four with the stereometer in the upright position, and four with the stereometer upside-down), covering the front of the device while switching presentations. In order to avoid monocular depth perception cues, the subject's chin must be stabilized on a chin rest and the subject nose to test target distance must be 100 cm.

Normal range: No errors in any of the eight test bar presentations.

Examples:

Verhoeff 0/8 Pass

Verhoeff 1/8 Fail

### **Randot circles.**

Enter: Record the Randot circles binocular depth perception acuity (stereopsis) testing score as the best of ten test circle rows correctly identified.

Notes: View the Randot circles test plate at normal reading distance. Randot circles test plates fade over time, invalidating the test score. They may need replacement as often as every 12 months, depending on the degree of exposure to damaging ultraviolet light. During the fading process, the plates turn from whitish gray background color to brownish gray background color. The circle margins become less sharp.

Normal range:

Correctly identifies all test circle rows in rows 1 through 8 (equals 40 seconds of arc or better).

**Examples:**

Randot 1 thru 10 Pass  
Randot 1 thru 8 Pass  
Randot 1 thru 7 Fail

**21a. Distant visual acuity.**

Enter: Record the uncorrected distant visual acuity for each eye using the English Snellen Linear System (20/20). Record the number of errors on the best distant visual acuity line. If there is more than one error, record the next best Snellen line.

Enter: If the uncorrected visual acuity of either eye is worse than 20/20, enter the corrected distant visual acuity for each eye.

**Examples:**

20/20	(20/20 with no errors on the 20/20 line)
20/20 -1	(20/20 with one error on the 20/20 line)
20/30 corr 20/20	(20/30 corrected to 20/20)

Note: Enter 20/20 -2 as 20/25 since there is more than one error on the 20/20 line.

**21b. Near visual acuity.**

Enter: Record the uncorrected near visual acuity for each eye using the English Snellen Linear System (20/20). Record the number of errors on the best near visual acuity line. If there is more than one error, record the next best line.

Enter: If the uncorrected near visual acuity of either eye is worse than 20/20, enter the corrected near visual acuity for each eye.

**Examples:**

20/20	(20/20 with no errors on the 20/20 line)
20/20 -1	(20/20 with one error on the 20/20 line)
20/30 corr 20/20	(20/30 corrected to 20/20)

Note: Enter 20/20 -2 as 20/25 since there is more than one error on the 20/20 line.

**22. Intraocular tension.**

Enter: Measurement of the intraocular tension is required on initial FDME's and all FDMEs beginning at age 40 and older. Record the intraocular tension for each eye in mmHg (OD=right and OS=left).

Acceptable tests:

Non-contact tonometry (NCT)  
Applanation tonometry.

Unacceptable test:

Palpation

Normal ranges:

Less than 24 in each eye,  
Less than 4 mmHg difference between eyes.

Notes: If reading in either eye is 22 or greater but less than 24, repeat the readings in 7 days by applanation tonometry. Two measurements of 22 or above is abnormal, or a difference of 4 mm Hg between eyes, and requires an ophthalmology evaluation as per Aeromedical policy letter 6.

Examples:

NCT OD 12 / OS 14  
TA OD 17 / OS 17

### 23. Audiometry.

Enter: Using pure-tone testing procedures prescribed in TB MED 501, record the best hearing acuity for each ear in decibel units at the frequencies of 500 Hz, 1000 Hz, 2000 Hz, 3000 Hz, 4000 Hz, and 6000 Hz.

### 24. History and physical examination.

Counseling: Counsel the aviator on diet and exercise, substance use, sexual practices, injury prevention, cancer prevention, and immunizations, as required. Assess the aviator for significant change in life problems; such as active divorce or separation proceeding, situation depression, family loss or tragedies, or suicidal ideation.

Enter: **The medical history.** The aviator's medical history must be reviewed annually. This can be facilitated by review of medical records, the last FDME, and the last USAAMA AEDR medical history verification printout (see Appendix M).

Enter: **Laboratory tests.** Enter laboratory tests, in addition to those in Items 22 to 25, DA Form 4497-R, Appendix M, that may be required by policy letter, or waiver letter to maintain a waiver. Other laboratory tests are indicated by Army regulations, public health standard of care, or due to use of chronic systemic medications.

Additional laboratory recommendations:

**Females:**

Annual Papanicolaou smear.

Mammogram for active duty soldiers at ages 40, 42, 44, 46, 48, and 50, then annually.

Urinalysis for white blood cells and bacteria screening, and possible culture, for those with a history of recurrent urinary tract infections or current pregnancy.

Ensure history of positive titers for rubella immunity in childbearing ages, and repeat as required.

**Both genders:**

HIV screening every 2 years.

VDRL or RPR, chlamydial and gonorrhea cultures for those with history of sexually transmitted diseases, high risk sexual exposures, or sexually transmitted disease symptoms.

Colonoscopy for those with family history of familial polyposis coli or cancer family syndrome (rare finding in aircrew members).

PPD tuberculin skin test for those with close contact to patients with active tuberculosis.

Fasting blood sugar annually beginning age 40.

Fecal occult blood testing beginning age 40.

Enter: **The physical examination.** The interim examination should be directed at the personal history, or as required by Army regulations and the public health standard of care. Waiver letters may require specific followup examinations.

Additional physical examination recommendations:

**Females:**

Annual breast examination.

Annual pelvic examination.

**Males:**

Annual testicular examination, especially in men less than age 50 with a history of cryptorchidism, orchioepexy, or testicular atrophy.

Annual prostate examination beginning age 40.

**Both genders:**

Complete skin examination for those with history of skin tumors, precancerous skin lesions, or significant sun exposure, such as tour in Desert Storm operations or surfing.

Mouth examination for those with history of nicotine and snuff use, or chronic mouth ulcer.

Thyroid examination for those with history of upper-body irradiation.

Auscultation for carotid, aortic, and femoral bruits beginning age 40.

**25. Electrocardiographic findings.**

Enter: Resting electrocardiograms (fasting) are done for interim examinations only when indicated by history or physical examination, or as required by waiver or aeromedical policy letter.

**26. Recommendations.**

Enter: Circle recommendation as "Qualified" or "Disqualified." If disqualified, check "Continue waivers" or "New disqualification". New disqualifications will require an aeromedical summary, with SF88 and SF93 in some cases.

**27/28. Signature block.**

Enter: Aeromedical physician assistant and/or flight surgeon performing the examination apply their identification stamp and sign the interim FDME..



## Appendix G.

### Realignment of birth month for FDMEs after an out-of-cycle FDME

Normally, aircrew members undergo FDMEs for aeromedical recertification within 90 days of the last day of their birth month. The certification is valid until the last day of the next birth month, which is between 12 and 15 months depending on the date the certification was first issued upon completion of a FDME.

There are circumstances when an FDME and medical certification is done out of cycle with the birth month and the 90-day examination window. Example circumstances include flight training, prolonged temporary duties, deployments, flying evaluation boards, aeromedical summaries. Table G-1 is used to realign FDMEs with the birth month after an out-of-cycle FDME.

On Table G-1, find the birth month in the left hand column. Read across the row until intersecting with the month the out-of-cycle FDME was done. This number is the maximum number of valid months remaining until the next medical recertification and FDME is required, thus realigning the aircrew member with the normal birth month cycle. This period of validity may be anytime between 7 to 18 months as per Table G-1.

Table G-1.  
Realign birth month with FDME.

Birth month	The last FDME was done in this month											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Jan	12	11	10	9	8	7	18	17	16	15	14	13
Feb	13	12	11	10	9	8	7	18	17	16	15	14
Mar	14	13	12	11	10	9	8	7	18	17	16	15
Apr	15	14	13	12	11	10	9	8	7	18	17	16
May	16	15	14	13	12	11	10	9	8	7	18	17
Jun	17	16	15	14	13	12	11	10	9	8	7	18
Jul	18	17	16	15	14	13	12	11	10	9	8	7
Aug	7	18	17	16	15	14	13	12	11	10	9	8
Sep	8	7	18	17	16	15	14	13	12	11	10	9
Oct	9	8	7	18	17	16	15	14	13	12	11	10
Nov	10	9	8	7	18	17	16	15	14	13	12	11
Dec	11	10	9	8	7	18	17	16	15	14	13	12

## Appendix H.

### Guidelines for avoiding and correcting AEDR data entry errors

1. Write legibly in black ink.
2. Use only authorized abbreviations found in this guide and Army Regulation 40-6.
3. Perform all required tests and examinations from Appendix C.
4. Use only authorized entries from Appendices B, D, E, and F.
5. Adequately describe defects/conditions.
6. Transcribe all tests and lab results to Standard Form 88.
7. Have a physician read and sign ECG report or tracing.
8. Assemble the FDME forms in the order outlined in Appendix I.
9. Staple packet in upper left corner.
10. Submit an aeromedical summary with the FDME when disqualifying conditions are found.
11. Forward dental X-rays to dental clinic, rather than USAAMC.

### Correcting AEDR data entry errors

If the FDME is returned for more information, the reviewer has found:

1. A possible clerical error.
2. An item in which a required entry has not been made.
3. An entry which is outside the normal range but not commented on by the flight surgeon on the SF 88/93 or attached documents.
4. A response which requires elaboration before a disposition can be made by USAAMC.

These returns can be minimized by:

1. Carefully reviewing the FDME before submitting it.
2. Repeating any tests which are out of the normal range.
3. Commenting on all positive responses in the history.
4. Thoroughly exploring and documenting all abnormal findings, especially if those findings are potentially disqualifying.

When an FDME is returned for more information, the reviewer will specify what information is needed. Obtain the information, enter it in the proper space, or attach extra sheets, as necessary. Do not submit the FDME for review a second time without the requested information. Doing so may result in the aviator being disqualified for failure to complete the FDME.

If questions or problems arise, call or write the Commander, USAAMC, ATTN: MCXY-AER, Ft. Rucker, AL 36362-5333, DSN 558-7430 or COMM (334) 255-7430, FAX (334) 255-7606, for an aeromedical consultation with the aerospace medicine specialists on the staff at the Aeromedical Activity, U.S. Army Aeromedical Center.

## Appendix I.

### Forms and references for the flight surgeon's office.

#### Forms used in completing initial and comprehensive FDMEs.

1. Aeromedical summary, if required.
2. FDME cover sheet.
3. SF 88, physical examination.
4. SF 93, history.
5. Aeromedical continuation of SF 93 history forms (required for initial FDME), Appendix M.
6. SF 520, electrocardiogram.
7. SF 600, if required as a continuation SF 88 or SF 93.
8. SF 513, specialty consultation, if required.
9. SF 519-B, X-Ray report, if required.
10. Special tracings and reports, if required, such as graded exercise treadmill test, echocardiogram, 24 hour Holter monitor.
11. When individual exceeds the screening weight table in AR 600-9, submit DA Form 5500-R Body Fat Content Worksheet (Male), or DA Form 5501-R Body Fat Content Worksheet (Female).

#### Forms used in completing interim FDMEs

1. Aeromedical summary, if required.
2. FDME cover sheet.
3. DA Form 4497-R Interim medical examination (Short Form)
4. SF 520, electrocardiogram.
5. SF 600, if required as a continuation SF 88 or SF 93.
6. SF 513, specialty consultation, if required.
7. SF 519-B, X-Ray report, if required.
8. Special tracings and reports, if required, such as graded exercise treadmill test, echocardiogram, 24 hour Holter monitor.

#### Useful references for conducting FDMEs

AR 40-501, Standards of Medical Fitness.  
AR 40-8, Temporary flying restrictions due to exogenous factors.  
AR 40-XX, Army aviation medicine program (regulation in draft form).  
AR 600-9, The Army weight control program.  
AR 600-85, Alcohol and drug abuse prevention and control program.  
AR 600-105, Aviation service: Rated Army officers.  
AR 600-106, Flying status: Nonrated Army aviation personnel.  
APL 1 thru XX, Aeromedical policy letters (issued by Commander, USAAMC).  
ATB 1 thru XX, Aeromedical technical bulletins (issued by Commander, USAAMC).

### Other references for clinic administration

AR 40-2, Army medical treatment facilities: General administrative.  
AR 40-3, Medical, dental, and veterinary care.  
AR 40-21, Medical aspects of aircraft accident investigation.  
AR 40-26, Tuberculosis detection and control program.  
AR 40-48, Nonphysician health care providers.  
AR 40-63, Ophthalmic services.  
AR 40-66, Medical record and quality assurance administration.  
AR 40-535, Worldwide aeromedical evacuation.  
AR 40-562, Immunization requirements and procedures.  
AR 95-1, General provisions and flight regulations.  
AR 95-17, The Army aviation life support system program.  
AR 95-30, Participation in a military or civil aircraft accident safety investigation.  
AR 95-37, Army air traffic control: General provisions.  
AR 385-40, Accident reporting and records.  
AR 385-95, Army aviation accident prevention.  
AR 420-90, Fire protection.  
AR 500-4, Emergency employment of Army and other resources: Military assistance to safety and traffic (MAST).  
AR 616-110, Selection, training, utilization, and career guidance for Army medical corps officers as flight surgeons.  
DA Pam 385-95, Aircraft accident investigation and reporting.  
HSC Reg 40-5, Ambulatory patient care.  
HSC Pam 40-7-18, Prehospital emergency care and transportation.  
FM 1-300, Flight operations and airfield management.  
FM 1-301, Aeromedical training for flight personnel.  
TB Med 289, Aeromedical evacuation: Special problems in patient care.  
Army Special Text 1-105-8, Army flight surgeon's manual (out of print).

## Appendix J

### Aviation service and air traffic control waiver authorities.

Personnel who are dual-status, i.e., Army National Guard and DAC, will require a waiver or suspension action from each authority to which they are assigned. The authorities are:

1. Active Army or USAR- Classes 1/1A and Class 2: through Commander, USAAMC, ATTN: MCXY-AER, Ft. Rucker, AL 36362-5333; for Commander, PERSCOM, ATTN: TAPC-PLA, 200 Stovall Street, Hoffman Bldg, Room 3N25, Alexandria, VA 22332-0413.

2. Active Army or USAR- Class 2F and aviation audiologists, dentists, optometrists, and psychologists: through Commander, USAAMC, ATTN: MCXY-AER, Ft. Rucker, AL 36362-5333; for Commander, PERSCOM, Health Services Division, ATTN: TAPC-OPH-MC, 200 Stovall Street, Hoffman Bldg, Room 9N68, Alexandria, VA 22332-0417.

3. Active Army or USAR- Class 2S, Class 3 (for drug and alcohol waivers only), and Class 4: through Commander, USAAMC, ATTN: MCXY-AER, Ft. Rucker, AL 36362-5333; for Commander, PERSCOM, ATTN: TAPC-EPL-T, 2461 Eisenhower Ave, Alexandria, VA 22331-0453.

4. ARNG- Classes 1/1A, Classes 2/2F/2S/4, and Class 3 for drug and alcohol waivers: through Commander, USAAMC, ATTN: MCXY-AER, Ft. Rucker, AL 36362-5333; for Chief, National Guard Bureau, ATTN: NGB-AVN-OP, 111 South George Mason Drive, Arlington, VA 22204-1382.

5. Contract civilian- All classes: through Commander, USAAMC, ATTN: MCXY-AER, Ft. Rucker, AL 36362-5333; through the Contracting Officer Representative; for the Commanding General, or CG-designated waiver authority (usually airfield commander or command aviation officer; for example at Fort Rucker, Command Aviation Officer, ATTN: DPT-AD), of the installation with the DA contract. Final determination will then be forwarded to the Contracting Office and the firm under contract to the DA.

6. DAC- All classes: through Commander, USAAMC, ATTN: MCXY-AER, Ft. Rucker, AL 36362-5333; through aviation unit Commander; for the Commanding General, or Commanding General-designated waiver authority (usually airfield commander or command aviation officer; for example at Fort Rucker, Command Aviation Officer, ATTN: DPT-AD). Final determination will then be forwarded to the local Civilian Personnel Office.

7. Class 3, for other than drug and alcohol abuse/dependence: through the local flight surgeon; for the local aviation unit Commander.

## Appendix K.

### Reading aloud test

Administer the reading aloud test (RAT) to aviation training applicants as a standardized assessment of an individual's ability to communicate clearly in the English language, in a manner compatible with safe and effective aviation operations. Current communication systems degrade speech intelligibility. The radio environment separates the speaker and the listener from the benefits of watching lips and body language cues. Those with marginal English skills have problems communicating effectively in the operational aviation environment.

Failure of the screening RAT by applicants with English as their native language may indicate undiagnosed or concealed learning disabilities. Administration of the RAT occasionally reveals immature, indecisive, careless, or excessively introverted personalities, which may indicate a high risk for aviation training failure.

The RAT appears to be a nonsense story, but was designed as a phonetic exercise. Assessment by the flight surgeon is subjective. Applicants should read the RAT clearly, deliberately, without hesitation, error, or stuttering. In questionable cases, the flight surgeon might perform an in-flight evaluation. The test is scored as "RAT-PASS" or "RAT-FAIL."

Instruct the applicant to stand erect and read:

"You wished to know all about my grandfather. Well, he is nearly 93 years old; he dresses himself in an ancient black frock coat, usually minus several buttons; yet he still thinks as swiftly as ever. A long flowing beard clings to his chin giving those who observe him a pronounced feeling of the utmost respect. When he speaks, his voice is just a bit cracked and quivers a trifle. Twice each day he plays skillfully and with zest upon our small organ. Except in winter when the ooze of snow or ice is present, he slowly takes a short walk each day. We have often urged him to walk more and smoke less, but he always answers, 'Banana oil!' Grandfather likes to be modern in his language."

## Appendix L.

### Aeromedical standards summary sheet

Table L-1.

Summary of selected aeromedical standards.

Cycloplegic error				Visual acuity		Phorias		
Class	Hyperopia	Myopia	Astigmatism	Distant	Near	Eso	Exo	Hyper
1	>+2.00	>-0.25	>±0.75	20/20	20/20	8D	8D	1D
1A	>+3.00	>-0.75	>±0.75	20/50	20/20			
2/3/4	Not required			20/400	20/400			
Class	Cover test	NPC	Color vision	Field vision		Depth perception		IOP
1/1A	ortho	>100 mm	>4 errors PIP, or >0 errors FALANT	any visual field defect		>0 errors VTA lines A->D, or >0 errors in 8 Verhoeff sets, or >40 sec arc in Randot Circles (any error in lines 1->7 of 10)		>22mmHg,  or  >3mm Hg OSvsOD
Initial 2/3/4								
Other 2/3/4								
Acceptable audiometric hearing levels for Army aircrew members and ATC								
Class	500 Hz	1000 Hz	2000 Hz	3000 Hz	4000 Hz	6000 Hz		
1/1A	25	25	25	35	45	45		
2/3/4	25	25	25	35	55	65		
All Classes	Percent body fat limits	Age Male Female	17 to 20 20% 30%	21 to 27 22% 32%	28 to 39 24% 34%	≥40 26% 36%		
Male Female	RBC count		Anthropometrics			Class 1/1A		
	Hct	Hgb	Total arm span (TAR)			DQ less than 164 cm		
	40%-52%	14-18	Crotch height (LL)			DQ less than 75 cm		
	37%-47%	12-16	Sitting height (SH)			DQ greater than 102 cm		
Blood glucose mg/dl (75 gm GTT)			FBS	1 hour pp	2 hour pp	3 hour pp		
Normal			<115	<200	<140			
Impaired glucose tolerance			115-140	>200	140-200			
Diabetes mellitus			>140	>200	>200			
Gestational diabetes (100 gm GTT)			>105	>190	>165	>145		

Appendix M.

Blank aeromedical forms used by flight surgeons.



<b>INTERIM (ABBREVIATED) FLYING DUTY MEDICAL EXAMINATION</b> For use of this form, see AR 40-501; the proponent agency is OTSG						1. EXAM DATE (DD/MM/YY)			
2. NAME (Last, First, MI)			3. SSN		4. RANK		5. BIRTH DATE (DD/MM/YY)		
6. COMPONENT (Check one or more) <input type="checkbox"/> AD-RA <input type="checkbox"/> AD-USAR <input type="checkbox"/> USAR-AGR <input type="checkbox"/> USAR-TPU <input type="checkbox"/> USAR-IRR <input type="checkbox"/> ARNG-AGR <input type="checkbox"/> ARNG <input type="checkbox"/> DAC <input type="checkbox"/> CIV CONTRACTOR <input type="checkbox"/> RET-MIL					7. AVIATION DUTY (Check one) <input type="checkbox"/> AVIATOR <input type="checkbox"/> FS/APA <input type="checkbox"/> AEROSCOUT <input type="checkbox"/> CLASS 3 <input type="checkbox"/> ATC (CLASS 4)				
8. UNIT OF ASSIGNMENT AND COMPLETE UNIT ADDRESS					9. UNIT PHONE		10. HOME PHONE		
11. LIST YOUR AEROMEDICAL WAIVERS IN EFFECT					12. LIST YOUR MEDICATIONS AND DOSAGES  13. I understand that I must be cleared by a flight surgeon after hospitalization or sick in quarters, or after treatment or activities requiring restriction. I am informing the flight surgeon of my medical history or any change in my health since my last FDME. I have read AR 600-105 (Aviation service) and AR 40-8 (Exogenous factors).				
14a. EXAM FACILITY ADDRESS					15. BLOOD PRESS		16. PULSE		
					17. HEIGHT (ins)		18. WEIGHT (Lbs)		
					19. %BODY FAT				
b. EXAM FACILITY PHONE		c. AEDR FACILITY CODE		20a. DEPTH PERCEPTION TEST <input type="checkbox"/> VTA <input type="checkbox"/> VERHOEFF <input type="checkbox"/> RANDOT CIRCLES			b. TEST SCORE		
							c. TEST RESULT <input type="checkbox"/> PASS <input type="checkbox"/> FAIL		
21. EYE EXAMINATION				22. INTRAOCULAR PRESSURE		23. AUDIOMETRIC SCREENING (Decibels)			
	a. DISTANT VISION		b. NEAR VISION						
RIGHT	20/   corr to 20/		20/   corr to 20/		mmHg				
LEFT	20/   corr to 20/		20/   corr to 20/		mmHg				
24. HISTORY AND EXAMINATION. Enter pertinent history and physical findings below as per ATB 2. Continue on reverse, if required. If review of the most recent USAAMA AEDR History Verification Form shows no change in history, enter "No significant interval history."						25. ELECTROCARDIOGRAM FINDINGS			
						THIS BOX IS FOR USAAMA USE ONLY			
26. RECOMMENDATION <input type="checkbox"/> QUALIFIED <input type="checkbox"/> DISQUALIFIED, CONTINUE WAIVERS <input type="checkbox"/> NEW DISQUALIFICATION, SEND AEROMEDICAL SUMMARY AND SF 88/93									
27. AEROMEDICAL PHYSICIAN ASSISTANT STAMP AND SIGNATURE					28. FLIGHT SURGEON STAMP AND SIGNATURE				

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**MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA**

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For use of the form, see AR 40-400; the proponent agency is the Army Surgeon General

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Report title: Aeromedical continuation of SF 93, History

TSG approved 1 April 1996

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**CAUTION: Concealment of medical history** may result in a permanent medical disqualification.

1. Have you ever been disqualified by a flying duty medical examination (FDME)?	Yes ____	No ____
2. Since your last FDME or in the last 18 months, were you sick, injured, hospitalized, consulted a doctor, or used medication?	Yes ____	No ____
3. Have you ever used or experimented with illegal drugs, such as, but not limited to cocaine, marijuana, PCP, heroin, downers, speed, peyote, LSD, or any other substance considered illegal or dangerous by the US government?	Yes ____	No ____
4. Have you ever been evaluated for or had any mental health illness, such as depression, stress, anxiety, panic attacks, nervous breakdown, or fear of flying?	Yes ____	No ____
5. Have you ever used alcohol resulting in legal problems (such as driving under the influence), absence from school or work, medical problems (such as stomach ulcers, liver disease, blackouts, memory loss), or marital problems? Have you been treated for alcohol abuse or dependence?	Yes ____	No ____
6. Have you ever had surgery to correct cross eyes (strabismus), or poor eyesight to include surgical or laser procedures to change the shape of the cornea (clear eye part) to improve vision, such as radial keratotomy or laser keratoplasty?	Yes ____	No ____
7. Have you ever worn contact lens, including hard contact lenses to change the shape of the cornea (clear part of the eye) in order to improve vision?	Yes ____	No ____
8. Have you ever had a seizure or convulsion, vertigo or spinning dizziness, fainted or lost consciousness, or head injury with concussion and/or skull fracture?	Yes ____	No ____
9. Have you ever had a migraine, cluster headache, or other severe headache?	Yes ____	No ____
10. Have you ever been in special education classes, or had learning disabilities or difficulties, such as dyslexia?	Yes ____	No ____
11. Have you ever had asthma or wheezing, hayfever (allergic nasal problems), or sinus problems that required the use of medications, doctor visits, use of nasal steroid sprays, or allergy shot series?	Yes ____	No ____

*(Continue history on reverse, if required)*

Flight surgeon name stamp:	Flight surgeon signature:	Date:
Patient name and social security number:	Patient signature:	Date:

**DA FORM 4700 1 APRIL 1996**

**MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA**

For use of the form, see AR 40-400; the proponent agency is the Army Surgeon General

**Report title: Aeromedical continuation of SF 93, History (Side 2)**

*(Continue history here, if required)*

**MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA**

For use of the form, see AR 40-400; the proponent agency is the Army Surgeon General

**Report title: Aeromedical continuation of SF 93, Allergic rhinitis TSG approved 1 April 1996**

**CAUTION: Concealment of medical history may result in a permanent medical disqualification.**

1. Have you ever had hayfever or sinus problems? If yes, complete the form.	Yes ____	No ____												
2. State the age that you first had symptoms.	Age =													
2a. State the age that your symptoms last occurred.	Age =													
3. How many total weeks per year would your symptoms persist?	Weeks =													
3a. Circle the months your symptoms occurred.	<table border="0"> <tr> <td>JAN</td><td>MAR</td><td>MAY</td><td>JUL</td><td>SEP</td><td>NOV</td> </tr> <tr> <td>FEB</td><td>APR</td><td>JUN</td><td>AUG</td><td>OCT</td><td>DEC</td> </tr> </table>		JAN	MAR	MAY	JUL	SEP	NOV	FEB	APR	JUN	AUG	OCT	DEC
JAN	MAR	MAY	JUL	SEP	NOV									
FEB	APR	JUN	AUG	OCT	DEC									
4. Check items that aggravate your symptoms.	<table border="0"> <tr> <td>Grass ____</td><td>Weeds ____</td><td>Trees ____</td><td>Molds ____</td> </tr> <tr> <td>House dust ____</td><td>Mites ____</td><td>Cats ____</td><td>Dogs ____</td> </tr> <tr> <td>Feathers ____</td><td>Wool ____</td><td>Smoke ____</td><td></td> </tr> </table>		Grass ____	Weeds ____	Trees ____	Molds ____	House dust ____	Mites ____	Cats ____	Dogs ____	Feathers ____	Wool ____	Smoke ____	
Grass ____	Weeds ____	Trees ____	Molds ____											
House dust ____	Mites ____	Cats ____	Dogs ____											
Feathers ____	Wool ____	Smoke ____												
5. Have doctors and/or nurses treated your symptoms?	Yes ____	No ____												
6. Did you ever have allergy skin or allergy blood tests?	Yes ____	No ____												
6a. Test results were?														
7. Check medications you have used. Decongestants ____ Antihistamines ____														
Nasal steroids ____ Steroid shots ____ Inhaled cromolyn (Spinhaler) ____ Allergy shots ____														
7a. How many weeks per year would you use medication?	Weeks =													
7b. How many years did you take allergy shots?	Years =													
8. Check other problems you have had. Nasal polyps ____ Sinusitis ____ Sinus surgery ____														

Flight surgeon: record current test results-  
 Patient have symptoms during your testing? Yes \_\_\_\_ No \_\_\_\_  
 Nasal smear for eosinophils-  
 Blood eosinophil count-  
 Serum IGE level-  
 Sinus X-ray series-

*(Continue history on reverse, if required)*

Flight surgeon name stamp:	Flight surgeon signature:	Date:
Patient name and social security number:	Patient signature:	Date:

**DA FORM 4700 1 April 1996**

**MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA**

For use of the form, see AR 40-400; the proponent agency is the Army Surgeon General

**Report title: Aeromedical continuation of SF 93, Allergic rhinitis (Side 2)**

*(Continue history here, if required)*

**MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA**

For use of the form, see AR 40-400; the proponent agency is the Army Surgeon General

**Report title: Aeromedical continuation of SF 93, Alcohol**

**TSG approved 1 April 1996**

**CAUTION: Concealment of medical history may result in a permanent medical disqualification.**

1. Have you ever felt you should cut down on your drinking alcohol?	Yes ___	No ___
2. Have people ever annoyed you by criticizing your drinking?	Yes ___	No ___
3. Have you ever felt bad or guilty about your drinking?	Yes ___	No ___
4. Have you ever had problems at, or missed school/work due to drinking?	Yes ___	No ___
5. Have you ever had to drink alcohol in the morning to steady your nerves or treat a hangover?	Yes ___	No ___
6. Have you ever been arrested for problems due to alcohol misuse, such as driving under the influence, disorderly conduct, or family fighting?	Yes ___	No ___
6a. If so, when?		
7. Have you ever attended Alcoholics Anonymous, Al-Anon, Al-Ateen, or similar organizations because of your own drinking?	Yes ___	No ___
8. Have you ever been in an outpatient or inpatient alcohol abuse or alcohol dependence treatment program?	Yes ___	No ___
8a. If so, when and where?	Yes ___	No ___
9. How old were you when you had your first drink?	Age =	
10. Describe your current drinking habit. Check all of those that apply to your habit. What do you drink? Beer ___ Wine ___ Liquor ___ When do you drink? Daily ___ Weekly ___ Weekends/Days off only ___ Monthly ___ Rarely ___ With whom do you drink? Alone ___ With family ___ With friends ___ With bar patrons ___ State how much you drink in one sitting. Compared to past years, do you? Drink the same ___ Drink less ___ Drink more ___		

Flight surgeon comments:

*(Continue history on reverse, if required)*

Flight surgeon name stamp:	Flight surgeon signature:	Date:
Patient name and social security number:	Patient signature:	Date:

**DA FORM 4700 1 April 1996**

**MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA**

For use of the form, see AR 40-400; the proponent agency is the Army Surgeon General

**Report title: Aeromedical continuation of SF 93, Alcohol (Side 2)**

*(Continue history here, if required)*

**MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA**

For use of the form, see AR 40-400; the proponent agency is the Army Surgeon General

**Report title: Aeromedical continuation of SF 93, Drugs**

**TSG approved 1 April 1996**

**CAUTION: Concealment of medical history may result in a permanent medical disqualification.**

1. Have you ever used illegal drugs, such as but not limited to, marijuana, cocaine, LSD, barbiturates, amphetamines, PCP, etc? If yes, complete the form.	Yes ____	No ____
2. What drugs did you use? Describe frequency and total amount of drugs used (ex. weekly for 1 year). Marijuana: _____ Cocaine: _____ Speed: _____ LSD: _____ Others (name them): _____		
3. Have people ever annoyed you by criticizing your drug use?	Yes ____	No ____
4. Have you ever felt bad or guilty about using illegal drugs?	Yes ____	No ____
5. Have you ever had problems at, or missed school/work due to drug use?	Yes ____	No ____
6. Have you ever been arrested for problems due to drug misuse, such as driving under the influence of drugs, disorderly conduct, or family fighting?	Yes ____	No ____
6a. If so, when?		
7. Have you ever attended drug abstinence support organizations because of your own drug use?	Yes ____	No ____
8. Have you ever been in an outpatient or inpatient drug abuse or drug dependence treatment program?	Yes ____	No ____
8a. If so, when and where?	Yes ____	No ____
9. How old were you when you first used drugs?	Age =	
10. How old were you when you last used drugs?	Age =	

Flight surgeon comments:

*(Continue history on reverse, if required)*

Flight surgeon name stamp:	Flight surgeon signature:	Date:
Patient name and social security number:	Patient signature:	Date:

**DA FORM 4700 1 April 1996**



**MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA**

For use of the form, see AR 40-400; the proponent agency is the Army Surgeon General

**Report title: Aeromedical continuation of SF 93, Drugs (Side 2)**

*(Continue history here, if required)*

### Use of USAAMA medical history verification printout

Beginning in 1994, the Aviation Epidemiology Data Register (AEDR) generates a USAAMA medical history verification printout (MHVP). This printout is returned with each FDME to the flight surgeon's office. The medical history verification printout contains the AEDR consolidated SF 93 divided into multiple sections as shown in Table M-1.

Table M-1.  
Sections of the USAAMA medical history verification printout.\*

Section	Description
1	Identifies the patient by name, Social Security number, birth date, and printout date.
2	Lists all of the patient's FDMEs on file in the AEDR.
3	Lists all of the patient's waiver and suspense file actions on file in the AEDR. Some common waiver requirements may be listed in Section 3.
4	History of positive responses the patient made on page 1, SF 93.
5	Chronologic history taken from page 2, SF 93.

\* **CAUTION:** The AEDR consolidated SF 93, from MHVP sections 4 and 5, is a dynamic computer medical history file that is updated continuously by USAAMA staff. Sometimes, the content lags behind findings in the Waiver and Suspense File (WSF), MHVP section 3. For example, the local flight surgeon may submit a graded exercise treadmill test (GXT) with the initial finding of "Normal." It will be entered into the AEDR SF 93 history as "Normal GXT." However, upon later review by AAMA and aeromedical cardiology consultants, the GXT is found to be "Aeromedically abnormal," a common event. The "Abnormal GXT" will be entered into WSF database, but does not always get updated in the AEDR consolidated SF 93 file. The flight surgeon reviewing the MHVP might see this confusion. The WSF entries are the final recommendations from USAAMA, and in the case of history conflict, take precedence over Sections 4 and 5, MHVP.

#### Disposition of the medical history verification printout.

1. File the MHVP with the current FDME. During the next FDME, the patient and flight surgeon will review the last MHVP.
2. If there are no corrections or new medical history, the flight surgeon may enter on the SF 93 or DA Form 4497-R, **"No interim change in history since the medical history verification printout dated ... (state date of the printout)."** Thus the flight surgeon and patient will not have to reenter old history over and over again, as in the past.
3. If the MHVP requires correction, make corrections on the MHVP and attach copies of supporting documents. Send the MHVP with the new FDME for correction of the AEDR SF 93.
4. If there is new medical history, add the new history to the SF 93 or DA Form 4497-R. Attach supporting documents and aeromedical summary as required.

Medical history verification form example

*SF 93, Report of medical history verification sheet for:*

Frank A. Aviator    SSN: 999887777    Data of birth: 601231    As of: 941205

*has the following physicals on file at AAMA with the status as noted:*

Physical Date	Name	Class	Status Date	Status
920714	F A Aviator	AB	920903	QU Qualified
930630	F A Aviator	AA	930915	WR Waiver recommended
940708	F A Aviator	AB	941024	WC Waiver continued

*has the following waivers and annual requirements:*

Date	FS	AM	PE	ICD9	Medications	Limitations
930915	WR	WG	2720	(W) Hypercholesterolemia (W) Annual waiver requirement- annual lipid profile E70 Cholestyramine resin (Questran)		
940723	QI		7966 G340 G922 7965A	(I) Abnormal Level 1 Cardiovascular risk screening (I) Normal graded exercise treadmill test (I) Normal cardiac fluoroscopy (I) Normal Level 2 Cardiovascular risk screening		

*has indicated the following positive responses on the SF 93:*

Wear glasses or contact lenses  
Back pain

*This is the chronological history given by Frank A. Aviator:*

Age	Code	Comment
	9591	Acute back injury
	---->	Acute back strain resolved, 1992

*The above reflects the medical history on file at AAMA for the service member:*